



Authorization Release

Thomas M. Siler, M.D.
Frank S. Calandrino, Jr., M.D.
Christine Champagne, N.P.
Angela McDonnell, N.P.
Katie L. Pilla, N.P.

TO:

FROM:

Name:
Address:
Phone #:
Fax #:

Name:
Address:
Phone #:
Fax #:

Patient Last Name Patient First Name MI

Patient Address Patient Phone Date of Birth

I request the following information be released:

- All Medical Records
Itemized Billing Statement
Diagnostic Testing (X-ray, CT scan, PFT, cardiac etc...)
Primary Care Records (provider name)
Specialist Records (provider name or specialty)
Other (specify):
Laboratory Report(s)
Pathology Reports(s)
Sleep Study Report(s) with data

This request is limited to the following date(s) of treatment:

- Date (MM/DD/YYYY):
Dates From (MM/DD/YYYY): To (MM/DD/YYYY):
All Dates of Treatment

Test results and/or diagnosis and treatment information, if any, concerning substance use/abuse, psychiatric/behavioral health information, OBGYN records (include pregnancy test results), and AIDS/HIV and other communicable diseases contained within my medical records indicated above will be released through this authorization unless indicated below.

Please indicate below any information that you DO NOT want released:

- Substance Use/Abuse
AIDS/HIV and other communicable diseases
Other (specify):
Psychiatric/Behavioral Health
OB/GYN Records

This medical information is for the purpose of:

- Self
Further medical care
Changing physicians
Disability
Workmans Compensation
Insurance Eligibility/Benefits
Attorney Name
Other (specify):

I understand that I may revoke this authorization at any time except to the extent that prior action has been taken in reliance on this authorization. This authorization will expire one (1) year from the date it is signed if I do not cancel it in writing prior to the I understand that Midwest Chest Consultants, PC may not condition my treatment, payment for treatment, or enrollment/eligibility in a health insurance plan on obtaining this authorization.
By signing below I acknowledge and understand the above items

Patient/Legal Guardian/Personal Representative Signature: Signature Date