PULMONARY & SLEEP OF TAMPA BAY
TAMPA • WESLEY CHAPEL • BRANDON

Phone: 813-490-9495 or 813-654-8100
Fax: 813-654-6555
www.pulmonaryandsleephealth.com
4308 N. Habana Ave. Tampa, FL 33607

Patient name: _____ Date of Birth: _____

MEDICAL RELEASE FORM

I hereby authorize Pulmonary and Sleep of Tampa Bay group Doctors Dragos G. Zanchi, M.D., Rafael A. Martinez, M.D., ("The Practice") to obtain any and all medical records concerning my care from any physician, hospital or the health care profession that has provided medical care in the past. I also authorize the practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third party administrator, or managed care company.

Patient Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/ FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Health Care Portability and Accountability Act of 1996 (HIPAA), in order for your physician or staff of the practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so in the event of critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules be waived.

☐ I do not authorize the Practice to release any information concerning my medical care to any individual except as set forth above.

☐ I authorize the Practice to release any information concerning my medical care to the following individuals:

Name/ Relationship: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____