AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: ______________________________ DOB: ________________

I authorize BreatheAmerica to release my or my child's medical records (maximum of 3 visits) to the following providers when requested to do so by me or by the provider/provider's office listed below.

This authorization is also valid to release records to myself (maximum of 3 visits).

Records in excess of 3 visits will require a different authorization form to be signed.

This authorization shall expire in ONE YEAR unless otherwise specified:

____

(Specify date, event, or condition of expiration; may be less than one year but cannot exceed it.)

Please list provider's name (ex: Dr. John Doe) or provider's office (ex: ABC Primary)
Do not list general descriptions (ex: my pulmonologist at Presbyterian)

PROVIDER NAME OR OFFICE:	PHONE NUMBER:
1. ______________________	______________________
2. ______________________	______________________
3. ______________________	______________________
4. ______________________	______________________
5. ______________________	______________________
6. ______________________	______________________

______________________________________ ________________
Signature of Patient or Parent of Minor Patient Date

Signature and date required to be valid

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