Millennium Physicians
Respiratory & Sleep Disorder Specialists

Amrew Al-Ahmad, MD • Ariffin Alam, MD • Wael Asi, MD • Mohsin Bajwa, MD • Salah Fares, MD • Jefy M. Mathew, MD
Amarbir S. Mattewal, MD • Hammad N. Qureshi, MD • William A. Rhoton, MD • Humberto C. Sasieta, MD • Ather J. Siddiqi, MD

Authorization for Disclosure of Confidential Information

Patient Name: _____

Date of Birth:_____ SSN:_____

Street Address:_____

I hereby authorize Respiratory and Sleep Disorder Specialists to:

Release to:_____ Receive from:_____

Name of Person/ Facility:_____

Street Address:_____

City, State, Zip: _____

Phone/Fax:_____

Please fax records to 281-419-1291

_____History & Physical	**_____Discharge Summary**	**_____PFT**
_____ Progress Notes	**_____Sleep studies**	**_____Lab Results**
_____ Pathology Results	**_____Radiology Reports**	**_____Other:_____**

This authorization covers patient care given from _____ to _____.

Purpose of Disclosure: _____Medical Care _____ Attorney _____Insurance _____Other

I understand that I may revoke this authorization in writing at any time, except to the extent that the action has been taken in reliance on it and that in any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here:

_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state regulations.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Respiratory & Sleep Disorders Specialists