PSI Pulmonary & Sleep INSTITUTE, PA

Office Information:
540 Madison Oak, Suite 500
San Antonio, Texas 78258
P: (210) 494-4220
F: (210) 494-4227

Patient Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ SS#: _____-_____-_____

I hereby authorize the physician / practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information contained in my medical records) to DAVID A. MARKS, M.D., P.A. and affiliated healthcare providers.

Disclosing Physician / Practice: _____ Phone: (_____) _____-_____

Description of Information to be disclosed:

_____ Complete Medical Record
_____ Chest X-Rays
_____ Echocardiograms
_____ Office Notes
_____ Labs Reports / Tests
_____ Nuclear Stress Test
_____ EKG Test / Results
_____ Holter Monitor Results

Protected Health Information to be disclosed to:

DAVID A. MARKS, M.D., P.A.
Attn: MEDICAL RECORDS
540 MADISON OAK, SUITE 500
SAN ANTONIO, TX 7825
PHONE: (210) 494-4220

Purpose of Disclosure:

_____ Continuing Care
_____ Referral to Specialist
_____Change of Doctor
_____ Other: _____

I understand the following:

1). I may revoke this authorization at any time by providing written notice to David A. Marks, M.D.,P.A.
2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3). DAVID A. MARKS, M.D., P.A. will not condition treatment or payment based upon my signing of this Authorization.
4). The information disclosed by this authorization may be subject to re-disclosure by David A. Marks, M.D., P.A. no longer protected by Federal Law.
5). I have reviewed this Authorization and understand its purpose and intent
6). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

_____ _____ _____
Patient Signature Date Name (if other than Patient)