

MidState  
PULMONARY

Breathe. Sleep. Heal.

# INFORMATION RELEASE

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. Drs. Tyson, Peacock, Carpenter, Capizzi, Pritchett, Atwater, Ferrell, Burk, Kha, Wigger and/or a member of their office staff may release medical information to a specified person other than myself.  
 Yes  No If yes, please list authorized persons and their relationship to you below.

**Authorized Person**

**Relationship**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Only the persons listed above will be allowed to receive your medical information.**

2. What medical information can be released?

Laboratory Results  Yes  No

X-ray Results  Yes  No

Medications  Yes  No

Medical Status  Yes  No

Appointment dates/times  Yes  No

3. If we need to contact you regarding your appointment and we get your answering machine may we leave a message on your machine?  Yes  No

If someone else answers the phone, may we leave a message?  Yes  No

May we call you on your cell phone?  Yes  No Cell phone # \_\_\_\_\_

4. What is the best phone number for us to call with test results? Phone # \_\_\_\_\_

5. If unable to reach you by phone, may we mail your results?  Yes  No

If yes, to what address do you want us to send the results?  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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