

MidState
PULMONARY

Breathe. Sleep. Heal.

INFORMATION RELEASE

Patient Name: _____ DOB: _____

1. Drs. Tyson, Peacock, Carpenter, Capizzi, Pritchett, Atwater, Phillips, Ferrell, Burk, Kha 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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