PULMONARY SLEEP &
CRITICAL CARE SPECIALISTS

Carlos E. Maas, MD, FACP, FCCP, FAASM
Fabrizio Monge, MD, FCCP, D, ABSM
Lohaliz Bobé, MD, FCCP
Edgardo Soto, MD, FCCP

AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO: _____

I hereby authorize and request you to release to/obtain from: Carlos E. Maas, MD, Fabrizio Monge, MD, Lohaliz Bobe', MD and /or Edgardo Soto, MD aka Sleep & Pulmonary Center of Florida.
Please fax records to: (941) 613-1779

The Following Information:

☐ Office Visits ☐ Pulmonary Function Tests ☐ Sleep Studies

☐ Laboratory Reports ☐ Echocardiograms ☐ EKG Reports

☐ Chest Xray Reports ☐ Chest CT Scans ☐ PET Scans

☐ Other (please specify): _____

EXCEPT the following, which may not be disclosed:_____

From the Medical Record of: _____

Print patient name DOB

_____

Address Social Security Number

For the purpose of: _____ Any and all information I hereby authorize to be obtained from this agency / facility will be held in the strictest confidence and cannot be release by the recipient without my written consent. I understand that this authorization will remain in effect for ninety days (90) unless I specify a different time frame here: _____. I understand that I may withdrawal my consent at any time.

_____ _____

SIGNATURE DATE

_____ _____

Legal Representative Relationship to Patient

Use this space ONLY if patient withdrawals his/her consent to release medical records.

_____

WITNESS Date

_____

Signature

4235 Kings Highway, Suite 103 . Port Charlotte, FL 33980 . P 941.613.1777 . F 941.613.1779
25086 Olympia Avenue, Suite 300 . Punta Gorda, FL 33950 . P 941.205.5300 . F 941.205.5302