**Lung Associates P.A.**

**Sleep Disorders Clinic P.A.**

**M.P Rampertaap, MD, FCCP**

**Board Certified: Internal Medicine, Critical Care Medicine, Pulmonary Medicine, Sleep Medicine**

Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, authorize the release of, or request access to the information specified below from the

medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care

 Military Social Security/Disability

Insurance

Personal Use

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Purposes School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical

Consultation Report

 Emergency Room Record

Operative Reports

Discharge/Death Summary

Face Sheet

Lab/Path Reports X-Ray Reports/Images

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information may be released (specify name or title of the individual or the name of the organization to which

records are to be released and the appropriate address):

**TO:**

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

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

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

Address (Street, City, State and ZIP)

**FROM: LUNG ASSOCIATES, PA- DR. MOONASAR RAMPERTAAP**

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

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

**203 3RD AVE EAST BRADENTON, FL 34208**

***PHONE 941-741-8633***

***FAX 941-741-8632***

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

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when

otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure

by the recipient and no longer protected. I understand that the specified information to be released may

include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or

communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in

reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to

that time.

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

Patient or Legally Authorized Representative

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

Printed Name of Patient or Legally Authorized Representative