Pulmonary Associates, P.C. PROTECTED
HEALTH INFORMATION FORM

I, _____, give permission for Pulmonary Associates, P.C. or their staff, to release information to:

_____ Spouse (name) _____

_____ Friend (name) _____

Phone (if different) _____

_____ Family Member (name) _____

_____ Other (name) _____

Phone (if different) _____

_____ May we notify you of your appointment by phone

_____ May leave information on your answering machine

Signature:_____

Date of Birth:_____ Date signed: _____

Witness:_____