AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, ______________________________, authorize MIDWEST PULMONARY ASSOCIATES to disclose my Protected Health Information to the following person or persons:

1.____ Relationship __________________DOB____

2. ____ Relationship __________________DOB____

3. ____ Relationship __________________DOB____

I understand that I may revoke this authorization at any time.

____ Date ____________________
Signature of Patient/Person Authorized as POA