Patient Name: ______________________________ Date of Birth: ________________

Telephone Number: ______________________________

Provider Name: ______________________________

Type of Form (FMLA, DOT, Disability): ______________________________

Reason form is needed: ________________ Fax, mail, or call to pick up: ________________

Information released from:

Fox Valley Pulmonary Medicine

Information to be released to:

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Fax Number: ______________________________

Do you need medical records, such as office note or test results? Yes _____ No _____

If yes, do you authorize FVPM to release any and all medical records pertaining to the completion of this form? Yes _____ No _____

I understand that this document is valid for ONE YEAR from the date signed. Initial: __________

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Signature: ______________________________ Date: ________________

Reason for signature from entity other than patient: ______________________________