

**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.

Signature of Patient/Person Authorized as POA

Date _____