

**AUTHORIZATION TO TRANSFER MEDICAL RECORDS**

I hereby authorize \_\_\_\_\_

\_\_\_\_\_

to furnish and transfer to: **Mitchell L. Petusevsky, M.D.**  
**Center for Sleep and Pulmonary Medicine**  
**700 2<sup>nd</sup> Ave North**  
**Suite 305**  
**Naples, FL, 34102**  
**Phone 239-263-8385 Fax 239-263-8592**

a copy of any and all medical records which are currently in the possession of:

\_\_\_\_\_

\_\_\_\_\_

regarding my physical condition and any medical treatments rendered to me.

For purposes of this Authorization, medical records shall include, but not necessarily be limited to, radiology and laboratory reports and results; descriptions and results of all tests of any type; descriptions, visual or audio-visual recordings and narrations of all diagnostic and surgical procedures; hospital records; treatment or practice plans; and all records pertaining to history, conditions, treatment, diagnosis, prognosis, and etiology of my medical condition and/or my personal health, including all records obtained from other physicians, from hospitals and from other health care providers.

A photocopy of this Authorization shall be accepted with the same authority as the original. This Authorization shall be effective for one (1) year from the date listed below.

\_\_\_\_\_

**Patient's Name Printed**

\_\_\_\_\_

**Date of Birth**

\_\_\_\_\_

**Patient's Signature**

\_\_\_\_\_

**Date Signed**

\_\_\_\_\_

**Relationship to Patient if Patient Unable to Sign**  
**(e.g., Guardian, Parent, or Authorized Representative)**