

J E F F R E Y M . S H E A , M . D . , P . A .  
P U L M O N A R Y / C R I T I C A L C A R E M E D I C I N E

O F F I C E : ( 9 0 3 ) 7 5 8 - 1 4 6 4

F A X : ( 9 0 3 ) 7 5 8 - 4 3 6 6

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**RELEASE OF MEDICAL RECORDS**

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NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ DATE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

INFORMATION TO BE RELEASED:

\_\_\_\_\_ ENTIRE CHART                      \_\_\_\_\_ EXAM/EVALUATION                      \_\_\_\_\_ TREATMENT  
\_\_\_\_\_ DIAGNOSIS                      \_\_\_\_\_ HOSPITALIZATION                      \_\_\_\_\_ OTHER (SPECIFY)

DATE OF TREATMENT:

PURPOSE OF DISCLOSURE (WHY ARE RECORDS REQUESTED)

I HEREBY REQUEST THAT MEDICAL RECORDS BE RELEASED TO:

**PULMONARY CRITICAL CARE ASSOCIATES OF EAST TEXAS  
DR. JEFFREY M. SHEA / CATHERINE M. MARTINEZ  
709 HOLLYBROOK DR., SUITE 3400  
LONGVIEW, TX 75605**

FROM:

\_\_\_\_\_  
Clinic/Physician

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

WAIVER OF LIABILITY:

I waive all rights and privileges allowed by law relating to disclosure of confidential information, defamation, invasion of rights of privacy and release the above person(s) or agency(ies) from legal responsibility or liability arising from this request for medical records.

Note: The original copy is in the patient medical record and may be reviewed upon request. This is a duplication of the original, and unless otherwise noted, is identical to the original.

I understand this release may be revoked at any time, but such revocation may not be applied retroactively once such information has been released in good faith.

NOTICE: The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS.

\_\_\_\_\_  
PATIENT OR AUTHORIZED SIGNATURE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE

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