

**Easy Breathe, Inc.**

11859 Wilshire Boulevard, Suite 510

Los Angeles, CA 90025

Email: [info@easybreathe.com](mailto:info@easybreathe.com) Office: (866) 564-2252

**Patient Release Prescription Records Form**

I, \_\_\_\_\_, authorize my physician and/or his/her administrative staff to disclose my medical records to:

**Via mail or courier:**

Easy Breathe, Inc.

11859 Wilshire Boulevard, Suite 510

Los Angeles, CA 90025

**Via Email:**

[info@easybreathe.com](mailto:info@easybreathe.com)

**Via Fax:**

(877) 883-9709

This authorization shall remain in effect :

Until I revoke it in writing.

Until the date of: \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time provided that I do it in writing.

\_\_\_\_\_  
SIGNATURE of patient or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
PRINT name of patient or personal representative

\_\_\_\_\_  
Date