Pulmonary & Critical Care Associates, P.C.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION (Please print)	
Name:	**Date of Birth:**

1. By my signature below, I authorize Pulmonary & Critical Care Associates, P.C. to release my health information, which pertains to me (referred to herein as "Protected Health Information") for the following purpose:

   Medical Reasons: _____

2. I authorize Pulmonary & Critical Care Associates, P.C. to release the following information (check all that apply):

   - ☐ All records
   - ☐ Office notes (previous 2 years)
   - ☐ Laboratory/pathology records (previous 3 years)
   - ☐ Radiology records (previous 3 years)
   - ☐ Billing records
   - ☐ Pharmacy/prescription records
   - ☐ Sleep studies/Titration Reports
   - ☐ Other _____

3. I authorize Pulmonary & Critical Care Associates, P.C., to release my Protected Health Information to the following persons/entity:

   _____
   Provider/Entity Name

   _____
   Provider/Entity Address

   _____
   Provider/Entity Phone/Fax

4. I understand that the Protected Health Information, which is used as disclosed pursuant to this Authorization, may be subject to re-disclose by the recipient and may lose protection of confidentiality under the privacy rules. [Please note: with the exception of psychotherapy notes [164.508(a)(2)].

5. I understand that I have the right to inspect or copy the Protected Health Information that will be used or disclosed pursuant to this Authorization.

6. I understand that Pulmonary & Critical Care Associates, P.C., will not condition any aspect of my treatment, payment, enrollment in the health pan, or eligibility for benefits on whether or not I sign this Authorization.

7. I understand that I am under no obligation to sign this Authorization.

8. I understand that this Authorization shall not be valid for greater than one year from date of signature.

9. I have the right to revoke this authorization, except to the extent of the custodian of records and/or Pulmonary & Critical Care Associates, P.C., has relied on it, by sending a written request to: *Practice Manager – 50505 Schoenherr Road, Suite 290, Shelby Township, MI 48315*

Patient Signature:_____ Date:_____

_____ _____

Printed name of patient/patient representative

Representative's authority to sign
(i.e. parent, guardian, POA, executor, etc.)