PULMONARY & CRITICAL CARE ASSOCIATES

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(Please Print)

PATIENT INFORMATION		
Patient Name:		**Date of Birth:**
Street Address:	**City, State, Zip:**	**Phone:**

According to HIPAA (Health Insurance Portability & Accountability Act) regulations, each patient must be assured that his or her medical records are held in the strictest confidence. In order for Pulmonary & Critical Care Associates to comply with these regulations, we ask that you take a moment to complete the following:

I authorize Pulmonary & Critical Care Associates to disclose the above-mentioned individual's health information as described below:

- ○ All healthcare information
- ○ Health care information relating to the following treatment, conditions, or dates:_____

_____

This information may be disclosed to and used by the following person or organization: (Please list family members, friends, physicians and/or medical personnel. HIPAA regulations prohibit disclosure of information to people/organizations not identified below):

Name of Person/Organization	Relation	Address	Phone/Fax Number

Please answer the following questions regarding answering machine/cell phone voicemail use:
When calls are made to your home or cell phone, confirming your appointment, may appointment times and test instructions be left on your home answering machine or cell phone voice mail? ○ Yes ○ No
When awaiting lab or test results, may we leave results on your home answering machine or cell phone voicemail? ○ Yes ○ No

I understand that Pulmonary & Critical Care Associates, P.C. will adhere to the regulations as outline by HIPAA and will follow the guidelines as I have outlined them.

Patient Rights:

1. I understand that I have the right to inspect or copy the Protected Health Information that will be used or disclosed in accordance with this Authorization.
2. I understand that I may refuse to sign this Authorization and that refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility of benefits, unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.
3. I understand that if I sign this Authorization, I have the right to change my mind and revoke (cancel) it at any time by my signing a Revocation of Authorization to Disclose Protected Health Information form.

Signature of Individual or Legal Representative:	Date:
Legal Representative's Name (if applicable)	Legal Representative's Relationship to Individual (A letter of authority may be requested)