PULMONARY AND MEDICINE ASSOCIATES

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

** * * All sections are required to be filled out in order for the request to be processed * * **

Patient Information:

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number: _____

Name of requestor if not patient: _____

Records to be provided from: (Enter physician or office name the information is coming from)

Facility/ Provider name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone number: _____ Fax number: _____

Send Records To: (Enter the office or person the information is being released to)

Person/Facility/Agency name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone number: _____ Fax number: _____ **E-mail:** _____

Information to be Disclosed: **Dates of Service Requested** _____ **To** _____

☐ Complete Record ☐ Office Notes ☐ Laboratory Reports ☐ Imaging/ Radiology

Other: _____

_____

I understand that the information contained in my health record may include information relating to sexually transmitted diseases, acquired or mental health services, and treatment of alcohol and/ or drug abuse. I authorize the release of all such items EXCEPT for those which I have marked below. By checking the boxes next to these items, I understand that the following information will NOT be released.

☐ Alcohol or Substance Abuse Records ☐ HIV and/ or STD testing and results ☐ Mental Health Records ☐ Genetic Records

By signing this authorization form I am authorizing the use or disclosure of protected health information as indicated above and I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/ state regulations. By submitting this request, I am accepting all associated fees and authorizing Pulmonary and Medicine Associates to have my request for records processed. Requests may be processed by a secure third-party medical records company contracted by the office.
- I understand that communication via email over the Internet is not secure. Although unlikely, there is a possibility that information in an email can be intercepted and read by other parties besides the person to whom it is addressed. The office has notified me of the risks and will not be held liable if I choose to have my records sent by email.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Pulmonary and Medicine associates. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Any disclosure of information carries with it the potential for re-disclosure, and the information may no longer be protected by federal confidentiality rules. Pulmonary and Medicine Associates shall not be held liable for any consequences resulting from re-disclosure.
- Unless otherwise revoked, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not I sign this authorization.

_____ _____ _____

Patient or Authorized Representative Signature **Date** **Relationship To Patient (if applicable or a minor)**

_____ _____

Witness Signature **Date**
(Required To Release Mental Health Records)

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