V-PaCC
Virginia Pulmonology and Critical Care LLC

4604 Spotsylvania Parkway
Suite 340
Fredericksburg, VA 22408
(540) 200-8272
info@v-pacc.com
"...spiro, spero..."

Authorization to Use or Disclose Protected Health Information

Patient Name: _____Date of Birth: _____

Daytime Telephone Number: _____

I, _____, understand Virginia Pulmonology and Critical Care is authorized by me to use or disclose my Protected Health Information (PHI) for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand the designated information will be disclosed only to the recipient(s) outlined below. I specifically authorize any current employee or owner of Virginia Pulmonology and Critical Care to disclose the information as outlined. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing at a later dates.

Description of the information to be used or disclosed (check all that apply):

☐ The patient's entire medical record

Note explanation as to why the entire record may be disclosed

☐ The patient's demographic information (check all that apply):

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☐ Name ☐ Address ☐ State/Zip Code only ☐ Telephone

☐ Age ☐ Gender ☐ Other _____

☐ Social Security Number ☐ Spouse's Name

☐ Name of Employer

☐ Certain Medical Data/Information as related to:

☐ Date of Service(s): _____

☐ Specific condition(s): _____ [ ]

Specific service(s) or procedure(s): _____ [ ]

Specific medication(s): _____ [ ]

Other: _____

☐ Other: _____

_____

Purpose(s) of the information:

_____

_____

☐ (Check if applicable) This authorization permits Virginia Pulmonology and Critical Care to send the protected health information ONLY to this name, address or fax number:

_____

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Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing. In order for the revocation of this authorization to be effective, Virginia Pulmonology and Critical Care must receive the revocation in writing. The revocation takes effect the date of the patient and practice signatures. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the PHI according to this authorization,
- The patient's reason to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Virginia Pulmonology and Critical Care will accept written revocations of this authorization via:

☐ Certified U.S. mail

ALL revocations must be sent to Virginia Pulmonology and Critical Care to the attention of the Privacy Officer and are not effective until received and signed by the Privacy Officer.

This authorization shall expire on _____. After this date, Virginia Pulmonology and Critical Care can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

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I fully understand and accept the terms of this authorization.

_____ _____

Patient or Legal Guardian Signature Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____.

Authorization received by _____ on _____.