TO RELEASE MR

Authority To Use Or Disclose Health Information

Patient Name:_____ **Date of Birth:**_____

PLEASE RELEASE THE FOLLOWING INFORMATION:

- [ ] Medication List
- [ ] Most Recent Progress Note For Visit
- [ ] History and/or Physical
- [ ] Entire Medical Record
- [ ] Any and/or All Lab Work
- [ ] Any and/or All X-rays or Imaging Reports
- [ ] Other_____

THE PURPOSE OF THIS REQUEST IS FOR:

- [ ] The Disclosure is at Patient Request
- [ ] Further Medical Care
- [ ] Disability Determination
- [ ] Insurance/Release
- [ ] Government Agency/Police
- [ ] Attorney/Legal Investigation
- [ ] Personal Use (Patient)
- [ ] _____

I HEREBY AUTHORIZE:

Pulmonary Consultants
6750 E Baywood Avenue, Suite 401
Mesa, AZ 85206
Telephone: 480-835-7111 FAX: 480-969-9345

TO DISCLOSE PROTECTED HEALTH INFORMATION RELATIVE TO MY TREATMENT AND CARE TO:

_____

_____

_____

I understand that the information in my health records may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will automatically expire within 12 months from the date signed below.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary, I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Patient or Legal Representative *Date*

If Patient is unable to consent by reasons of age, or some other fact, state reasons:_____

_____

_____ _____ _____

Legally Authorized Representative Date Relationship to Patient

Revised 11/2012

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