Pulmonary & Critical Care Associates, P.C.

Authorization to Disclose Protected Health Information

PATIENT INFORMATION (Please print all requested information)						
Name:				Date of Birth:		
Street Address:		C	ity, 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, P.C., to comply with these regulations, we ask that you take a moment to complete the following:						
I authorize Pulmonary and Critical Care Associates, P.C. to disclose the above-mentioned individual's health information as described below.						
 □ All healthcare information □ Healthcare information relating to the following treatment, condition, 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	Addre	ess		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 voicemail? 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 outlined by HIPAA and will follow the guidelines as I have outlined them.						
Signature of Individual or Legal Representative				Date	1	
Legal Representative's Name (If applicable)			Legal Representative's Relationship to Individual (A letter of authority may be requested)			
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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.