PULMONARY ASSOCIATES, P.C.
1725 East Boulder St., Suite 204 • Colorado Springs, CO 80909
(719) 471-1069 • Fax (719) 577-4828

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient _____ Birth Date _____

Street Address _____ City, State, Zip Code _____

I hereby authorize:

Name _____

Phone Number _____

Street Address _____

City, State, Zip Code _____

To disclose my protected health information, as described below, to:

Name of Individual or Entity _____

Phone Number _____

Street Address _____

City, State, Zip Code _____

Information to be released:

- ❑ Medical History, Examination Reports
- ❑ Treatment or Tests
- ❑ X-Ray Reports
- ❑ Laboratory Reports
- ❑ HIV Test Results*
- ❑ Mental Health
- ❑ Sexually Transmitted Disease
- ❑ Alcoholism
- ❑ Surgical Reports
- ❑ Hospital Records Including Reports
- ❑ Developmental Disabilities
- ❑ Prescriptions
- ❑ Consultations
- ❑ Allergy Records
- ❑ Drug Abuse
- ❑ Other (Please specify) _____

* A listing of the statutory exceptions to release of HIV text results without consent is available.

Purpose for Need of Disclosure

- ❑ At the request of the individual

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

ATTENTION MEDICAL RECORDS: The PRIVACY RULE permits physicians to disclose protected health information to another health care provider for treatment purposes. This can be done by fax or other means.

- **Receive Copy of This Authorization.**
- **Refuse to Sign This Authorization** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization,** except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s): _____

Signature of Patient (or Legal Representative) _____ Date _____

If signed by Legal Representative:

Relationship to Patient (authority to act on patient's behalf) _____ Date _____