

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:

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

Name _____

Name of Individual or Entity _____

Phone Number _____

Phone Number _____

Street Address _____

Street Address _____

City, State, Zip Code _____

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:

- ▶ **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.

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.

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 _____