Patient Authorization to Obtain Medical Information

MEDICAL RECORDS DEPARTMENT

201 East Kennedy Blvd. Suite 700 Tampa, FL 33602
Phone: 855-823-3216 Fax: 800-974-3092

Patient name: _____ Phone: _____

Date of birth: _____ Last 4 SS#: _____ Email: _____

Current address: _____

City: _____ State: _____ ZIP: _____

I hereby request and authorize the Lung Health Institute to release a copy of my medical records, containing protected health information, to the below entity:

- Name of provider: _____ Phone number: _____

  Fax number: _____ Address: _____

This authorization will expire 1 year from signature date or when revoked by the patient, legal guardian, power of attorney, or health care surrogate. 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 request to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once the information is disclosed, it may be redisclosed by the recipient and the information may not be protected under federal privacy laws or regulations. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

_____ _____

Signature of Patient/Guardian/Power of Attorney/Health Care Surrogate Date

_____ _____

Printed name Relationship to Patient if Applicable

Use one form for each entity you wish the Lung Health Institute to disclose your health information to. You may copy this form as often as needed.