PMD Pulmonary Medicine OF DAYTON

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name-_____ **Date of Birth-**_____/_____/_____

Telephone #-(_____)_____-_____ **Last 4 digits of SSN-**_____

I hereby authorize _____*to release, use, and disclose health information about me as described below to the following individuals or entities:*

Send To:

_____

_____

_____

Send To:

_____

_____

_____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

RELEASE CONTENT

Dates of Service Requested: _____

- ☐ COMPLETE MEDICAL RECORD
- ☐ PROGRESS NOTES
- ☐ HISTORY & PHYSICAL
- ☐ LAB/PATHOLOGY REPORTS
- ☐ EKG REPORTS
- ☐ PFT REPORTS
- ☐ DICTATED LETTERS
- ☐ ITEMIZED BILL
- ☐ RADIOLOGY REPORTS
- ☐ OTHER (PLEASE SPECIFY): _____

REASON FOR DISCLOSURE

My health information is being released or disclosed for the following reason(s) (check all that apply)

- ☐ PERSONAL
- ☐ LEGAL INVESTIGATION OR ACTION
- ☐ INSURANCE ELIGIBILITY OR BENEFITS
- ☐ CHANGING PHYSICIANS
- ☐ OTHER (PLEASE SPECIFY): _____

CONSENT

I understand that I may revoke authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____

Signature of patient (or patient's personal representative) Date

_____ _____

Printed name of patient representative Representative's authority to sign for patient, *(i.e. parent, guardian, power of attorney for healthcare, executor)*