



**Lung Care &
NOTICE OF PRIVACY PRACTICES**

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize Lung Care & to disclose the above-named individual's health information as described below.

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

- | | |
|--|--|
| <input type="checkbox"/> Complete health records | <input type="checkbox"/> Lab results/X-ray reports |
| <input type="checkbox"/> Physical exam | <input type="checkbox"/> Consultation reports |
| <input type="checkbox"/> Immunization records | |
| <input type="checkbox"/> Other (please specify): _____ | |

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization.

Name: _____	Relation: _____
Name: _____	Relation: _____
Name: _____	Relation: _____
Name: _____	Relation: _____

I understand that I have a 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 revocation to Lung Care &. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my action.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

I have received a copy of the Privacy Practices at Lung Care &. _____ Yes _____ No

Patient Name

Date

Patient Representative (if applicable)

Date