Lung Care &
NOTICE OF PRIVACY PRACTICES

Authorization for Disclosure of Health Information

Patient Name: _____
Date of Birth: _____ Phone: _____
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).

____ Complete health records
____ 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: _____ Phone#: _____
Name/Relation: _____ Phone#: _____
Name/Relation: _____ Phone#: _____
Name/Relation: _____ Phone#: _____
Name/Relation: _____ Phone#: _____

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.

_____ _____
Patient Name Date

_____ _____
Patient Representative (if applicable) Date

<u>In Case of Emergency Contact the following person(s):</u>

Name:

Phone:

Relationship:

**Form 06012024