Citrus Pulmonary Consultants and Sleep Disorders Center

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I hereby authorize the use or disclosure of information from the medical record of:

Name: _____ Date of Birth: _____

I authorize the following individual or organization to ❑ receive ❑ disclose the above named individuals health information:

Facility/Office: _____

Phone Number: _____ Fax Number: _____

This information may be ❑ received ❑ disclosed by Citrus Pulmonary Consultants and Sleep Disorders Center.

This information will be used for the purpose of: _____

Please release the following:

❑ Entire Record ❑ History & Physical ❑ Progress Notes ❑ Medication List ❑ X-Ray Films

❑ X-Ray Report ❑ Lab Results ❑ Problem List ❑ Other Diagnostic Testing:_____

❑ Other:_____

I understand that the information in my health record may include information relating to sexually transmitted diseases, 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.

❑ *Yes, I consent to the release of this information.* ❑ *No, I do not consent to the release of this information.*

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. 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 the individual or organization releasing the information. I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____. 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 ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____ _____
Signature of Patient/Legal Representative | Date | Relationship - Representative

Complete below only if information is to be released directly to the patient.

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Citrus Pulmonary Consultants and Sleep Disorders Center liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____ _____
Signature of Patient/Legal Representative | Date | Relationship - Representative