Greenville Pulmonary Associates
Authorization to use or disclose Protected Health Information

Patient Name______________________________ DOB_____________________

Health care Provider authorized to disclose this information:

Name____

Address ____

Tel ___________________________ Fax_________________________

Family members who can receive this information

Name____

Tel: ______________________

Specific information to be disclosed

___Medical record from (Date)____________ to (date) _________

___ Entire medical record including patient histories, office notes, test results, radiology studies,referrals,consults,billing records, insurance records,

___ Drug, Alcohol ,Substance abuse records

___ Mental health records

___ HIV/Aids related information

___ Genetic information

This authorization is voluntary. Treatment ,payment, eligibility for benefits will not be conditioned upon my signing of this authorization form

I understand that I have the right to revoke this authorization at any time by writing to the health care provider.

I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient/Legal representative signature________________________ Date ______________