LUNG HEALTH INSTITUTE

Authorization to Release Protected Health Information to Lung Health Institute

MEDICAL RECORDS DEPARTMENT
201 E. Kennedy Blvd., Suite 700, Tampa, FL 33602 | Phone: 888-356-2547 | Fax: 800-974-3092

Patient name: ______________________ Phone: ______________

Date of birth: __________ Last 4 SS#: __________ Email: ______________________

Current address: ______________________ City: __________ State: _____ ZIP: _______

I hereby request and authorize the below providers/facilities to release a copy of my medical records, containing protected health information, to Lung Health Institute. I understand that this authorization will thereby allow Lung Health Institute and the providers listed below to disclose and discuss my protected health information as required for adjunct therapy.

- Name of provider: ______________ Phone number: __________ Fax number: __________
  Address: ______________________________
- Name of provider: ______________ Phone number: __________ Fax number: __________
  Address: ______________________________
- Name of provider: ______________ Phone number: __________ Fax number: __________
  Address: ______________________________

FOR OFFICE USE ONLY

Please provide the patient's **most current** medical records for each of the selected items below to Lung Health Institute's medical records department via fax at **1-800-974-3092** or email to ______________________.

For questions, please call ______________________ at ______________.

- ☐ CBC w/diff
- ☐ BMP/CMP
- ☐ Pulmonary function test
- ☐ Last office note
- ☐ Chest X-ray or CT
- ☐ Other ______________

I understand the information in my medical 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 authorization will expire 1 year from signature date or when revoked by the patient, legal guardian, power of attorney, or health care surrogate. I understand that I have the 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 request to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once the information is disclosed, it may be redisclosed by the recipient and the information may not be protected under federal privacy laws or regulations. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

______________________________ ______________
Signature of Patient/Guardian/Power of Attorney/Health Care Surrogate Date

______________________________ ______________
Printed name Relationship to Patient if Applicable