Authorization to Verbally Discuss Health Information

Please fax this completed form to Lung Health Institute's Medical Records Department at **800-974-3092.**

You may choose to give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information when you are not present. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records. Complete this form to let us know to whom we may speak about your information.

HERE ARE SOME EXAMPLES OF WHEN IT MIGHT BE USEFUL FOR YOU TO RELEASE INFORMATION:

- If you want a relative or friend to help you understand medical treatment instructions
- If a relative or friend is helping with billing instructions
- If a relative or friend calls to verify your appointment time
- If a relative or friend comes in and asks if you are here and in or out of the procedure room

Patient name: _____ Date of birth: _____

I hereby authorize Lung Health Institute to discuss and disclose specific health information as selected below to the following entity/individual.

Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone number: _____ Relationship: _____

DESCRIPTION OF SPECIFIC INFORMATION TO BE DISCUSSED AND DISCLOSED (PLEASE CHECK ALL THAT APPLY):

- ☐ All health and treatment information
- ☐ Appointment date/times
- ☐ Lab/test results
- ☐ Billing/payment information
- ☐ Other: _____
- ☐ Medical information (including symptoms, diagnosis, medication, and treatment plan)
- ☐ Procedure status/location (whether I'm waiting to go into procedure or have been released)

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.

EFFECTIVE DATES FOR THIS AUTHORIZATION

Authorization automatically expires 1 year from the date signed below. You have the right to revoke this authorization before the year has passed.

BY SIGNING, I UNDERSTAND THAT:

- I may inspect or copy the protected health information to be used or disclosed.
- I may notify the medical practice in writing if I would like to revoke this authorization.
- This authorization is giving the Lung Health Institute permission to discuss my health information as selected above with entity/individual listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization, and that this authorization is not a condition of treatment or payment.

PATIENT/LEGAL REPRESENTATIVE

_____ _____

Signature Date

_____

Printed name