Tucson Pulmonology, PC

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## AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Legal Name:_____DOB_____
Address:_____
City:_____State:_____Zip Code:_____
Contact Telephone No. _____(h)/(c)/(w)Purpose of the Requested Use or Disclosure is: _____ Medical Care; _____ At My Request;
_____ For Medical Publication and Educational Purposes; _____ Marketing; _____ Insurance Verification; _____ Other: _____

**I hereby authorize Tucson Pulmonology to release to** the Recipient identified below, the following protected health information, including any confidential HIV/AIDS-related information, confidential communicable disease-related information, genetic testing and/or information relating to any mental health and/or alcohol/drug use for the period from _____ to _____:

_____History and Physical Examination
_____Progress Notes
_____Laboratory Reports
_____Imaging Reports
_____Medical Record
_____Consultations
_____Photographs, Videotapes, Digital/other Images
_____EKG
_____X Ray films
_____Other (please specify below)

(Other)_____

Recipient:_____
Address:_____
City:_____State:_____Zip Code:_____
Fax No._____Contact Person:_____

I understand that I may revoke this authorization at any time by notifying Tucson Pulmonology in writing, except to the extent that action based on this authorization has already been taken. Unless revoked, this authorization will expire on _____. If no date is provided, it shall automatically expire six months from the date on which it is signed. I agree to allow information to be faxed if necessary.

***Notice:*** Tucson Pulmonology may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. Unless otherwise protected by federal privacy laws, information disclosed pursuant to this authorization may be subject to redisclosure by the Recipient and may no longer be protected by federal privacy laws.

_____ _____
Signature of Patient/Personal Representative Date

*If you are a Personal Representative, you must provide a description of your authority to act for the patient.

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INTERNAL USE ONLY

Date records sent_____Sent By_____