HOLY NAME PULMONARY ASSOCIATES, PC

DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE
PULMONARY DISEASE, *CRITICAL CARE MEDICINE AND ↑SLEEP MEDICINE

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	**Date of Birth:**	**Home Phone:** **Office Phone:**
Patient Address:		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New Jersey State Law and the Privacy Rule of the Health Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. I have the right to revoke this authorization at any time by writing to **HOLY NAME PULMONARY ASSOCIATES** at the address listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

3. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

4. Name and address of the health provider or entity to release this information:

HOLY NAME PULMONARY ASSOCIATES

5. Name and address of health provider or other person(s) to whom this information will be sent:

6. Specific information to be released:
- ☐ Biopsy report(s) dated: _____
- ☐ Lab report(s) dated: _____
- ☐ Records and reports from _____to_____
- ☑ All records and reports
- ☐ Other (specify): _____

7. Reason for release of information:
- ☐ At request to individual
- ☐ Other: _____

8. Date or event on which this authorization will expire:
- ☐ _____**OR**
- ☐ INDEFINITE unless revoked or terminated by the patient or the patient's authorized repetitive.

9. If not the patient, name of person signing form:

10. Authority to sign on behalf of the patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of Patient or Representative Authorized By Law: _____ Date: _____

Witness: _____

NOTE: THIS AUTHORARIZATION IS **NOT** INTENDED TO AUTHORIZE DISCLOSURE OF INFORMATION RELATING TO ALCOHOL AND DRUG ABUSE, MENTAL HEALTH TREATMENT. AND CONFIDENTIAL HIV RELATED INFORMATION.