AUTHORIZATION TO
RECEIVE MEDICAL INFORMATION

INFORMATION TO BE RELEASED TO: TRI-COUNTY PULMONARY AND SLEEP CLINIC
2506 LAKELAND DRIVE, SUITE 300
FLOWOOD, MISSISSIPPI 39232
MAIN# 601.326.2599
FAX#: 601.933.0852

☒ Most Recent 1 Year Pertinent Information (Chart Notes / Radiology Tests / Prior Sleep Studies, If Applicable)

MY RIGHTS:

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be re-disclosed and no longer protected by the HIPAA regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed with this authorization. There may be a charge for these copies.

This authorization will automatically expire 1 Year from the date. I understand that I may revoke this authorization any time except to the extent that action has been taken in relationship thereon. To revoke this authorization I must submit my request in writing to Tri-County Pulmonary and Sleep Clinic.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE **DATE**