AUTHORIZATION TO RELEASE PATIENT INFORMATION

Tri-County Pulmonary & Sleep Clinic
2506 Lakeland Drive Suite 300 • Flowood, Mississippi 39232
Phone 601.326.2599 • Fax 901.933.0852

Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Patient Name: _____ **Date of Birth:** _____

Contact #: _____ **Email(Optional):** _____

I Authorize This Facility To Use Or Disclose My Health Information As Described Below.

1. **INFORMATION TO BE USED OR DISCLOSED (Check Appropriate):**

☐ Discharge Summary	☐ Chest Imaging Results	☐ 6 Minute Walk Tests
☐ History And Physical	☐ Recent Lab Results	☐ Sleep Study/Titration
☐ Consultation Notes	☐ Office/Doctor Notes	☐ Compliance Download
☐ Chest Related Operative Reports	☐ Spirometry/Pulmonary Testing	☐ Overnight Oximetry Reports
☐ Echocardiograms		
☐ Other (Specify) _____		

Specific Date(S) Of Service: _____

CHECK ONE OF THE FOLLOWING:

- ❑ I **specifically authorize** that information related to HIV/AIDS, other sexually transmitted diseases, mental health, and/or substance abuse may be used or disclosed.
- ❑ I **do not authorize** the use or disclosure of HIV/AIDS, other sexually transmitted diseases, mental health, and/or substance abuse information.

2. **RECIPIENT OF INFORMATION** — The information identified above may be used by, or disclosed to, the following individual(s) or organization(s). **TCPS** to **RELEASE** Records **TO**:

NAME: _____

ADDRESS: _____

_____

PHONE NUMBER: _____

FAX NUMBER: _____

3. **PURPOSE OF USE OR DISCLOSURE** — The information identified above will be used for the following purpose(s). (Describe As Specifically As Possible): ❑ Continuation of Care ❑ Transfer of Care ❑ Other(Specify)_____

4. **THIS AUTHORIZATION WILL EXPIRE** (Insert Date Or Event): _____
   [If Left Blank, This Authorization Will Expire One (1) Year From The Signature Date]

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____

PRINT NAME OF PATIENT / AUTHORIZED REPRESENTATIVE | **SIGNATURE OF PATIENT / AUTHORIZED REPRESENTATIVE**

_____ _____

IF LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT: | **DATE:**

The Individual Signing This Form Agrees And Acknowledges As Follows:

I. **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

II. **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to **TCPS**. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

III. **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

SIGNATURE OF MINOR (IF APPLICABLE) **DATE:**