SHORE PULMONARY, P.A.

PULMONARY DISEASES – CRITICAL CARE MEDICINE
INTERNAL MEDICINE & SLEEP DISORDERS

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HIPAA Compliant Medical Records Release

Patient Information (please print)

FULL NAME _____ DATE OF BIRTH _____

ADDRESS _____ HOME PHONE _____

CITY / STATE / ZIP _____ CELL PHONE _____

This authorization is in effect until I revoke it, in writing. I understand I have the right to revoke this authorization in writing, at any time. I also understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Information to Release (check one)

- ☐ All medical records as of the date of this release (this includes records relating to mental health, communicable diseases, HIV or AIDS and treatment of alcohol or drug abuse).
- ☐ All medical records except: _____
- ☐ Only the following information: _____

This medical information may be used for medical treatment, consultation, billing, claims payment or other purposes as I may direct. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I authorize Shore Pulmonary to either release records to / attain records from:

ORGANIZATION _____ PHONE _____

CONTACT NAME _____ FAX _____

CITY / STATE / ZIP _____

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

SIGNATURE OF PATIENT (OR REPRESENTATIVE) _____ DATE _____

PRINTED NAME OF REPRESENTATIVE AND RELATIONSHIP _____