Louisville Pulmonary Care PLLC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: ____

Date of Birth: ________________________________ Account Number: ___________________

I hereby authorize medical providers and personnel of Louisville Pulmonary Care to discuss my protected health and billing information with:

________________________________ ______________________________________
(Relationship) (Name)

________________________________ ______________________________________
(Relationship) (Name)

________________________________ ______________________________________
(Relationship) (Name)

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

____Information regarding the patient's diagnosis and treatment for HIV/AIDS
____Psychotherapy notes from a Psychiatrist or Psychotherapist
____Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from ___________until ___________at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization.

____________________________________ ______________________________________
Signature of Patient/Personal Representative Name of Patient/Personal Representative

_________________________ ______________________________________
Date Description of Personal Representative's Authority