Lake Pulmonary Critical Care, PA
1876 Nightingale Lane
Tavares, FL 32778
(352)742-4447
(352)742-4448

Authorization for Release of Medical Records
HIPPA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164***

**** 1. Authorization** Please complete**

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to **Lake Pulmonary Critical Care, PA** (individual seeking the information).

****2 Effective Period** Please check one**

This authorization for release of information covers the period of healthcare from:
Please check all that apply

____ A. From _____ To _____.

OR

____ B. All past, present, and future periods.

** OR**

____ Specific Records listed below.

_____

****3 Extent of Authorization** Please check one**

____ a. I authorize the release of my complete health records (including records relating to the mental healthcare, communicable disease, HIV or AIDs, and Treatment of alcohol or drug abuse).

** OR**

____ b. I authorize the release of my complete health record with the **exception** of the following information:

___ Mental health records

___ Communicable disease (including HIV and AIDS)

___ Alcohol/drug abuse treatment

___ Other (please specify): _____

Patient Name: _____ DOB: _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payments or other purposes as I may direct.

5. This authorization shall be in force and effective until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a 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.

7. I understand that my treatment, payment, enrollment or eligibility for benefits will not conditioned on whether I sign this authorization.

8. 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 personal representative Date

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Witness Date

Patient Name {printed}: _____ DOB: _____

Last 4 of SS# _____

Lake Pulmonary Critical Care, PA 1876 Nightingale Lane Tavares, FL 32778 Phone (352) 742-4447 Fax (352) 742-4448
Frank J. Montoya, M.D.
Rosemary A. Cirelli, M.D., FCCP