MAINLAND
PULMONARY ASSOCIATES

H.I.P.A.A. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____Date of Birth: _____

Social Security #: _____Phone Number: (_____)_____

Home Address:_____

City: _____State: _____Zip: _____

I request Mainland Pulmonary Associates to release any and all medical information regarding the patient named above to:

FAMILY:

Name:_____ Name:_____

Name: _____ Name: _____

(Such medical information includes, but is not limited to lab results, referrals, appointment confirmation and billing information.)

_____Request DENIED. I do not want my medical information released to anyone other than myself.

_____I give authorization for any and all medical information to be left on my voicemail.

_____I do not give authorization for any and all medical information to be left on my voicemail.

I understand that an expressed consent is required to release any health care information to testing, diagnosis and/or treatment for HIV (AIDS virus), STDs, psychiatric disorders/mental health or drug and /or alcohol use. If I have been tested, diagnosed, or treated for HIV, STDs, psychiatric disorders/mental health or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature of Patient or Patient's Authorized Representative: Date Signed:

_____ _____

Relationship or status if signed by anyone other than the patient (parent, legal, guardian, personal, representative, etc.:

_____-

*****THIS AUTHORIZATION SHALL REMAIN VALID UNTIL REVOKED IN WRITING*****