pulmonary & sleep CONSULTANTS

mary wuebben wellness

Today's Date: _____
Date needed by: _____
☐ To be picked up
☐ To be mailed
☐ To be faxed to _____

AUTHORIZATION FOR THE USE OF DISCLOSURE OF HEALTH INFORMATION

Patient Identification	Name:		Date of Birth:			
	Address:		Phone:		Cell:	
	City/State/Zip:					
	Maiden/Previous Names/Nickname:					
Provider (Who is releasing the information?)	Provider/Facility Name:					
	Address:		Phone:			
	City/State/Zip:					
Disclose Information To (Where is the information being sent?)	Name/Facility:					
	Address:					
	City/State/Zip:					
	Phone:		Fax:			
Information to be Disclosed	☐ All Records	☐ Lab Data	☐ Other:			
	☐ Clinic Progress Notes	☐ Pathology Reports				
	☐ X-ray Reports					
Purpose of Disclosure (Please be Specific)	☐ Continuing Medical Care	☐ Consult / Second Opinion	☐ Out of town move			
	☐ Insurance Claim	☐ Legal	☐ Personal			
	☐ Other (Specify):					
Expiration Date	This **authorization will expire** one year from the date of signature or on:					
Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization: or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.					
Authorization	I hereby authorize the above facility/provider to disclose medical information concerning the above named patients to the party identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.					
	Signature of patient/representative		Signature Date			
	(Relationship to patient, if signed by representative)		Witness (optional)			
	Please supply proof of authority to act. For minors, proof only required if other than parent.					
Disposition	For office use only:					
	Date sent:		Sent by:			
	Chart #:					