



Pulmonary and Critical Care Associates

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Authorization for Release of Protected Health Information

Date of Request: _____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, consistent with applicable State and Federal law. Failure to provide all information requested may invalidate this authorization.

I hereby authorize _____ to *disclose* the

(First and Last Name of provider or facility releasing records)

(Phone Number – Fax Number)

following information from the health records of:

Patient name: _____ Date of birth: _____

Address: _____ City _____ State _____ Zip _____

Telephone: _____ SSN (optional): _____

Information to be disclosed:

- Complete health record (s)
 - Discharge Summary Progress notes
 - History and physical examination Laboratory test results
 - Consultation reports X-Ray reports
 - Other (please specify): _____

I understand that unless otherwise noted, this will include information relating to (if applicable):

- AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection
- Mental health treatment records, such as psychiatric care and social service information
- Treatment for alcohol and/or drug abuse
- Check this box if you **DO NOT** give authorization to disclose this information.

This information is to be *released* to:

Name of person or facility: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Fax: _____

My health information will be used or disclosed for the following purpose(s) (ex: continued care, claims, legal, etc.):

I understand this authorization will expire 90 days from the date of signature unless submitted in writing to the above address or otherwise noted: _____

I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information. I understand that the 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 acknowledge that there may be a charge for reproduction of my medical records as described on the reverse of this form and may require a prepayment. I understand that I will receive a statement directly from HealthPort for this service if applicable. Actual postage and Michigan State tax will be included.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent authorized herein.

Signature of patient or legal representative date

Relationship to patient (if representative)



COPYING OF MEDICAL RECORDS

This facility has contracted with HealthPort to process your request for medical records. The State of Michigan has become a regulated state for the pricing of copying of medical records and the following rates went into effect:

January 1, 2011

COPIES FOR PATIENTS. There will be a charge to patients for medical record requests. The charge for this service will be:

\$1.10 per page 1-20 pages
\$.55 per page 21-50 pages
\$.23 per page 51+ pages
Plus shipping and handling

NOTE: HealthPort has capped patient personals to a \$25 max plus shipping, handling and any taxes that may apply.

If you have any questions regarding these fees, please direct your calls to the HealthPort Customer Service Department at 1-800-367-1500.