PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand Respiratory Medicine Consultants ("RMC") is authorized by me to use or disclose my Protected Health Information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize RMC or his/her designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed *(check all that apply)*:

☐ My entire record
(NOTE: This requires an explanation of why it is necessary to disclose the entire record) _____
_____

☐ My demographic information *(check all that apply)*:
☐ Name ☐ Address ☐ State/Zip Code only ☐ Telephone
☐ Age ☐ Gender ☐ Race ☐ Other: _____

☐ Medical Data/Information as related to:
☐ Specific condition(s)_____
☐ Specific professional service(s):_____
☐ Specific medication(s):_____
☐ Other:_____

☐ Other:_____
_____

Please disclose the above information to:

Name:_____ Telephone:_____

Address:_____

I ☐ do ☐ do not authorize this information to be faxed. If yes, Fax #:_____

Name(s) or class of person(s) to whom RMC may disclose my Protected Health Information:_____
_____

Purpose(s) for disclosure of the information:
_____
_____

(*Note:* If the patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure.")

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, RMC must receive the revocation in writing, and the revocation must include:

- My name and address,
- The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
- My desire to revoke this authorization, and
- The date of the revocation, and my signature.

RMC will accept written revocations of this authorization via:

☒Certified U.S. mail
☒Facsimile at this number: 713-464-2976

ALL revocations must be sent to Leslie Haber, and are not effective until received by her.

This authorization shall expire on_____. After this date, RMC can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____	_____
Signature of Patient or Patient's Representative	Date
_____	
Name of Patient	
_____	_____
Name of Representative (if applicable)	Description of Representative's authority to act for patient

FOR OFFICE USE ONLY

☐ Authorization added to the patient's record on _____.
☐ Authorization verified by _____on_____.
☐ Patient has been provided with a copy of the signed authorization