

**Pulmonary Associates of St. Augustine, P.A.**

Kishwar Husain, M.D. Javier Aduen, MD Marianne Michaels, ARNP

300 HEALTHPARK BLVD. STE 4000, ST.AUGUSTINE, FL 32086

TELEPHONE: 904-824-8666 FAX : 904-824-8933

**Medical Information Release Authorization**

Patients' full legal name: \_\_\_\_\_

Date of birth : \_\_\_\_\_ Social security Number : \_\_\_\_\_

Address: \_\_\_\_\_

Telephone : \_\_\_\_\_

Pursuant to HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. 134.512 & 164.508, I hereby authorize the following individual of the organization to disclose/release my protected health information, as described below:

Providers' Name: \_\_\_\_\_

Providers' Address: \_\_\_\_\_

Providers' Fax: \_\_\_\_\_ Telephone: \_\_\_\_\_

The purpose of the requested disclosure is: \_\_\_\_\_

The information to be used for disclosure includes the following (please check) :

|   |   |   |
|---|---|---|
| <input type="checkbox"/> Face sheet       | <input type="checkbox"/> Laboratory results   | <input type="checkbox"/> Substance abuse (alcohol/ drugs) |
| <input type="checkbox"/> Progress notes   | <input type="checkbox"/> Radiology reports    | <input type="checkbox"/> Mental health/Psych history      |
| <input type="checkbox"/> Hospital records | <input type="checkbox"/> Consultation reports | <input type="checkbox"/> HIV / AIDS related info          |

EXCEPTION: \_\_\_\_\_

I also understand that this consent may be revoked by me at any time by submitting a written revocation notice. I understand that the revocation will not apply to information that has already been released in response to or in reliance upon this authorization. This authorization will remain effective for a period of 90 days from date of my request.

Responsible party signature : \_\_\_\_\_

Relationship ( if applicable) : \_\_\_\_\_ Date : \_\_\_\_\_