HOWARD COUNTY CENTER FOR LUNG AND SLEEP MEDICINE, LLC
10910 LITTLE PATUXENT PARKWAY, SUITE 100
COLUMBIA, MD 21044
PHONE: 410-740-3635 FAX: 410-740-1253

Authorization for Use and Disclosure of Protected Health Information

_____ _____
Print Patient Full Name Birth Date

_____ _____
Street Address Social Security Number

_____ _____
City/State/Zip Telephone

I hereby authorize to Howard County Center for Lung & Sleep Medicine, LLC. to receive / release*:*

Type of Information to Be Disclosed

☐ Entire Medical Record	☐ Most Recent 5 Year History	☐ Radiology Reports
☐ Office Chart Notes	☐ All Hospital Records	☐ Operative Reports
☐ Billing Statements	☐ Transcribed Hospital Reports	
☐ Dental Records	☐ History and Physical Exam	☐ Other _____
☐ Laboratory Reports	☐ Emergency and Urgent Care Records	
☐ Pathology Reports	☐ Medical Records for Continuity of Care	_____
☐ Consultation	☐ Diagnostic Imaging Reports	
☐ Discharge Summary	☐ Emergency Room Reports	_____

In addition, I authorize that this will include health information relating to (check if applicable):
☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing

Information released from / to: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City/State/Zip /FAX telephone number

PURPOSE OF DISCLOSURE:

_____Referral to specialist	_____Insurance	_____Workers Comp	_____Personal
_____Change of Doctor/Provider	____Continuing care	_____Disability/Legal	_____Research

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying to Howard County Center for Lung & Sleep Medicine, LLC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Howard County Center for Lung & Sleep Medicine, LLC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Expiration:
This authorization will expire 180 days from the date of signing or **(insert date)** _____.

Patient Name: _____ **Patient Date of Birth:** _____

_____ _____
Signature of Patient or Legal Representative **Date**

Relationship to Patient (if applicable)
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

_____
Printed Name of Patient's Representative (if applicable)