AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Read entire document before signing

This authorization gives Heritage Valley Pulmonology and Sleep Medicine, permission to use and/or disclose health information about you.

RIGHT NOT TO SIGN: You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by Heritage Valley Pulmonology and Sleep Medicine except in the case of health care that is solely for the purpose of creating health care information for disclosure to a third party (for example: a pre-employment physical; research related care).

RIGHT TO REVOKE: You may revoke this authorization at any time except that we have relied on the authorization. To revoke this authorization, you must submit a written revocation to our privacy office at the following address:

Heritage Valley Pulmonology and Sleep Medicine
1000 Dutch Ridge Road
Beaver, PA 15009

RE-DOSCLOSURE: Health Information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by the federal privacy rule or another privacy law.

Authorized uses and disclosures

Print or type all information except signatures.

To ensure proper and timely handling of your test results, which have been ordered by your healthcare provider, please fill out the following information.

Home Phone Number: _____
Day Phone Number: _____
Alternate Phone Number: _____

I authorize the above named physician, physician group, or associates employed by the medical practice to release any and all medical test results or other medical information relating to my treatment to:

_____ May leave a message at work to call the physician
_____ May leave a message on the answering machine/voicemail to call the office
_____ May leave a message on the answering machine regarding test results/treatment
_____ May give test/instructions to the following designated person:
Name:_____
Address:_____
Phone Number:_____
Relationship: _____
_____ May only release test results to the patient

I understand this authorization will be in effect unless changed or revoked by me either in writing or by filling out a new release.

Date: _____ Patient Name:_____
Date of Birth:_____ SS#: _____
Address:_____

Signature: _____ Staff Initials: _____