Tri-State Pulmonary Physicians Authorization for Disclosure of Protected Health Information

I_____ hereby authorize Tri-State Pulmonary Associates Inc. to
(Name) (Date of birth)
_____Disclose (send) or _____Obtain (receive) the following health information from:

Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Specifically describe the information to be disclosed or obtained, including but not limited to, meaningful descriptors, such as date of service, type of service provided, level of detail to be released, origin of information, etc. _____

This protected health information is being disclosed/obtained for: _____

This authorization shall be in force and effective until _____ (specify date or event that relates to patient or purpose of the disclosure) at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification the Practice Administrator, Tri-State Pulmonary Associates, Inc., The Christ Professional Building, 2123 Auburn Ave., Suite 401, Cincinnati, OH 45219.

I understand that revocation is not effective to the extent that Tri-State Pulmonary Associates, Inc. has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Tri-State Pulmonary Associates, Inc. will not base my treatment, payment, or enrollment in a health Plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights), refuse to sign this authorization and to receive a signed copy of this authorization.

_____ _____
Signature of Patient or Personal representative (DATE) (Printed name)

_____
(Description of Personal Representative's Authority)