



Jose L. Diaz, MD, FCCP
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HIPAA COMPLIANT AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ ACCT# _____

I request and authorize medical records from the following facility:

I authorize to release information to the following person:

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

To release healthcare information of the patient named above to:

Pulmonary Group of Central Florida, LLC
1038 West North Blvd., Suite 102
Leesburg, FL 34748
Phone#352-315-1627
Fax # 352-326-8744

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information: _____

Other: _____

CONDITIONS OF AUTHORIZATION:

I MAY REVOKE THIS AUTHORIZATION IN WRITING. IF I DO, IT WILL NOT AFFECT ANY PREVIOUS ACTIONS ALREADY TAKEN IN RELEANCE UPON MY AUTHORIZATION. I MAY NOT BE ABLE TO REVOKE THIS AUTHORIZATION IF ITS PURPOSE WAS TO OBTAIN INSURANCE. I MAY REVOKE THIS AUTHORIZATION BY WRITING A LETTER AND MAILING IT CERTIFIED MAIL, RETURN RECEIPT REQUESTED, TO THE PRIVACY OFFICEER AT THE HEALTHCARE PROVIDER LISTED ABOVE. INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL PRIVACY REGULATIONS.

THIS AUTHORIZATION IS VALID FOR 90 DAYS FOR THE RELEASE OF INFORMATION AS INDICATED ABOVE. ONLY RECORDS FROM THIS FACILITY CAN LEGALLY BE RELEASED. ANY RECORDS FROM OTHER PHYSICIANS MUST BE OBTAINED FROM THEM.

Patient Signature & Date

Guardian Signature & Date

Witness Signature & Date