Central Florida Pulmonary Group, P.A.
Serving Central Florida Since 1982
Our physicians are Board Certified in Internal Medicine, Pulmonary Disease, Critical Care Medicine, and Sleep Medicine

326 N. Mills Avenue, Orlando FL 32803
Phone - 407-841-1100 Fax 407-843-7983

AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

I. PATIENT AND REQUESTOR INFORMATION

Patient Name:_____ Date of Birth _____ / _____ / _____

Address:_____ Social Security # (last 4 digits) _____

_____ Email:_____

Requestor Name: _____ Telephone #: _____

II. PERSON/FACILITY AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION:

Name: _____

Address: _____

Phone: _____

Fax: _____

III. PERSON/FACILITY AUTHORIZED TO OBTAIN THE PROTECTED HEALTH INFORMATION:

Name:_____ Phone: _____

Address/ Email:_____

Fax Number:_____

For Family Management Account Only: Date of Birth: ____/____/_____ Relationship to Patient: _____

IV. RECORDS REQUESTED AND METHOD OF DELIVERY

Format of Records: ❑ Paper ❑ Electronic (E-Mail / CD - Please Circle) ❑ Patient Portal

Method of Delivery: ❑ Mail ❑ E-Mail ❑ Pick-Up ❑ Fax (Medical Facilities Only)

Purpose of Disclosure: ❑ Personal Use ❑ Continued Treatment ❑ Insurance ❑ Legal ❑ School
❑ Family and Medical Leave Act/Disability Forms ❑ Patient Communication (Behavioral Health)
❑ Other (Please Specify): _____

Date Range of Records Requested: _____ to _____ **-OR-** ❑ **COMPLETE RECORD (All Records, All Dates)**

Type of Records: ❑ Abstract of Record ❑ Lab ❑ Pathology ❑ Radiology (CD) ❑ Radiology (Report) ❑ Therapy Records
❑ Progress Notes ❑ Consultation ❑ Operative ❑ All Diagnostic Test Results ❑ Other (Please Specify): _____

May NOT include information related to (please initial):
_____ HIV/AIDS ____ Mental Health ____ Drug and/or Alcohol Abuse ____ Genetic Counseling/Testing Information

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed above or otherwise required by law.

The authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I understand that I will receive a signed copy of this form.

_____ _____
Patient / Legal Guardian Signature: Date:

❑ I wish to revoke this authorization. Signature:_____ Date:_____

OFFICIAL USE ONLY:

Name_____Date:_____ ❑ Releasing Information

Number of Pages Copied: _____ ID Shown_____