PULMONARY CONSULTANTS
OF SOUTHWEST FLORIDA
Respiratory and Sleep Medicine
*Always there for you.*

## AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

PATIENT NAME______________________________DOB___________________
ADDRESS_________________________________________________________
CITY_________________________________STATE__________ZIP__________

This is an authorization under the Privacy Rules of the Health Insurance
Portability and Accountability Act of 1996 [45 CFR§164.508]. I authorize
Pulmonary Consultants of Southwest Florida, to obtain the following protected health information from:

*Name*__________________________________________________________________
*Address*________________________________________________________________
*Phone*_________________________________*fax*_____________________________

**PLEASE PROVIDE ALL PULMONARY RECORDS, TESTING, SLEEP STUDIES AND NOTES PRIOR**

The information to be disclosed to:
***Pulmonary Consultants of Southwest Florida***
***1031 SE 9th Place, Unit 2***
***Cape Coral, FL 33990***
***Fax 239-574-1451***

This protected health information is being used or disclosed at the request of the individual, for continuing treatment.
This authorization shall be in force and effect for one year from the request date
at which time this authorization to use or disclose this protected health
information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at Pulmonary Consultants of Southwest Florida. I understand that a revocation is not effective to the extent that Pulmonary Consultants of SWFL has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_______________________________________ ______________________
Signature of Patient or Personal Representative Date

_______________________________________
Print Name of Patient or Personal Representative