PREMIER LUNG & SLEEP INSTITUTE

155 School Street, Suite 260 • Tomball, Texas • 77375

Phone: 346-980-0110 • Fax: 346-980-0111 • Email: contact@premierlungandsleepinstitute.com

# Authorization for Release of Health Information

Patient Name: _____

Date of Birth: ___ / ___ / _____

Phone #: _____

Address: _____

## Section 1: Release Authorization

I hereby authorize Premier Lung & Sleep Institute to:
☐ Release health information ☐ Obtain health information ☐ Both Release & Obtain

To/From (Name/Organization): _____

Address: _____

Phone #: _____ Fax #: _____

## Section 2: Information to Be Released/Obtained

☐ Complete Medical Record
☐ Sleep Study Reports (Polysomnography, Home Sleep Test)
☐ Office Visit Notes/ER Visits/HPI/Consultations/Discharge Summaries/Hospital Visits
☐ Pulmonary Tests/ Reports
☐ Imaging/ Radiology Reports (X-ray, CT, MRI, etc.)
☐ Lab/ Pathology Results
☐ Other (specify): _____

## Section 3: Purpose of Disclosure

☐ Continuity of Care
☐ Insurance/Payment
☐ Legal
☐ Personal Use
☐ Other: _____

## Section 4: Expiration & Revocation

• This authorization will expire 12 months from the date signed unless otherwise specified: _____.

• I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

PREMIER LUNG & SLEEP INSTITUTE

## Section 5: Patient Rights & Acknowledgment

This authorization is for one year after I, or my personal representative, signs this form. I have the right to revoke this authorization in writing at any time to the Privacy Officer, except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damaged resulting from the lawful release of my protected health information.

## Section 6: Signatures

Patient / Legal Representative Name (Print): _____

Relationship (if not patient): _____

Signature: _____ Date: ___ / ___ / _____

Witness (if required): _____ Date: ___ / ___ / _____