Lung and Chest Medical Associates

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Authorization of Use and Disclosure of Protected Health Information

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and /or payment for your healthcare provided Lung and Chest Medical Associates?

(Please check all that apply)
____ Home Telephone May we leave a message? Yes/No (Circle One)
____ Work Telephone We will not leave a message. ____ Other __________________________

I authorize the persons/parties listed below to receive all health information about appointments, treatment and /or other information regarding my healthcare and / or payment for my healthcare provided at Lung and Chest Medical Associates.

1. ____
   Name of Relatives

2. ____
   Name of Physicians

3. ____
   Name of Pharmacy

4. ____
   Other

I would like the following restrictions regarding the use and disclosure of my health information:
____

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

- Do you give your permission for your medical record to be reviewed by staff from Spartanburg Medical Research, Dr. Charles M. Fogarty, for consideration in research studies that apply to your case? _____Yes ____No If yes may they contact you? _____Yes ____No

____ Date ___________________
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)
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Print Name of Patient

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