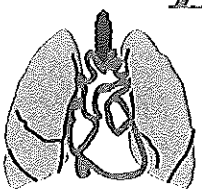
Lung and Chest Medical Associates



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Raul B. Cruz, M.D.
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J.P. Elm, F.N.P.
Cindy A. Edwards, F.N.P.
Nicole H. Jackson, F.N.P.
Charlene McCraw, ACNP-C

Patient Authorization to Release Medical Information

I hereby authorize employees, Medical Staff Members or other agents of (name of organization)

_____

to use or disclose the following information about me: _____

_____

For the following purposes:

_____ At the request of the undersigned individual

_____ Other (describe) _____

The health information described above may be used or released to :

_____

_____

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Patient Signature Date Date of Birth

_____

Patient printed name Witness Signature

****

The above individual is unable to consent. I therefore consent on behalf of the individual named above.

_____ _____

Signature Authorized Representative

_____ _____

Witness Signature Date

Please Fax Back to:

_____ Main Fax: 864-542-9043
_____ Insurance: 864-585-0999
_____ Nurse Station A: 864-582-3750
_____ Nurse Station B: 864-585-2102

2030 North Church Place
Spartanburg, South Carolina 29303
Phone: (864) 582-6858 · Fax: (864) 542-9043

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