

ST. PAUL LUNG CLINIC
Division of Pulmonary & Critical Care Associates, P.A.
Health Information Services

225 N. Smith Ave., #300
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(651) 298-0301 (fax)

1600 St. John's Blvd., #201
Maplewood, MN 55109
(651) 779-9322
(651) 779-9325 (fax)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Birthdate: _____

This will authorize _____
to release information to St. Paul Lung Clinic.

This will authorize St. Paul Lung Clinic to release records to:

Name/Organization

Street Address

City State Zip Code

Information to be used or disclosed:

I authorize the use or disclosure of the following protected health information:

Any and all medical records

Sleep study only

Records created between ___/___/___ (mm/dd/yy) and ___/___/___ (mm/dd/yy) about me: (describe the information as specifically as possible)

This information is to be released for the purpose of:

Continued care by another provider Insurance claim purposes Personal use

Attorney review Other _____

- I understand that I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here:_____.
- I understand there may be a retrieval and copy charge associated with the release.
- I understand that once information is released pursuant to this authorization, St. Paul Lung Clinic can not prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as an original.

Signature of Patient/Legal Representative

Relationship to Patient

Date