



CHEST MEDICINE ASSOCIATES

Pulmonary, Critical Care and Sleep Medicine

335 Brighton Avenue, Portland, ME 04102 P: (207) 828-1122 F: (207) 828-0188

Authorization for Chest Medicine Associates to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All my health information maintained by Chest Medicine Associates
- My health information relating to the following treatment or condition: _____

- My health information for the date(s): _____
- Other: _____

You may disclose this health information to:

Name (or title) and organization _____

Address: _____ City _____ State _____ Zip _____

Reason(s) for this authorization (check all that apply):

- at my request check here only when Chest Medicine Associates requests the authorization for marketing purposes
- other (specify) check here only when Chest Medicine Associates will get something of value for providing health information for marketing purposes

This authorization ends: on (date) _____

when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study

Or

- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Chest Medicine Associates based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office.

Or

- Write a letter the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, etc.)