SUNCOAST LUNG CENTER

HIPAA – CONFIDENTIALITY FORM

In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

It is the policy of Suncoast Lung Center not to release confidential and/or unauthorized information without patient permission, including detailed telephone messages on an answering machine or with another party unless indicated below.

May we reach you at home?	☐ Yes	☐ No
May we confirm your appointment(s) by leaving a message on your home answering machine?	☐ Yes	☐ No
If you are employed, may we contact you at work?	☐ Yes	☐ No
May we leave a message for you at work?	☐ Yes	☐ No

It is important to keep your other physicians informed about your care.

May Suncoast Lung Center release medical records to other physicians you see?	☐ Yes	☐ No
May Suncoast Lung Center fax medical records for referrals to another physician?	☐ Yes	☐ No

Authorization to release Protected Health Information (PHI)

I give consent and authorization to the person(s) listed below to have the right to obtain any and all Protected Health Information (PHI) from Suncoast Lung Center. This consent and authorization enables the person(s) listed below to obtain any and all billing information. This consent and authorization enables the person(s) listed below to pick-up sample medication and/or prescriptions on my behalf.

Please list names of authorized individuals:

Name: _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Name: _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Name: _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Do you have a Durable Power of Attorney / Living Will / Appointed Health Care Representative?

☐ Yes ☐ No *If "Yes", please provide a copy to our office.

I authorize Suncoast Lung Center staff to leave medical information pertaining to my care by the following methods indicated above and will assume responsibility to notify the office whenever this information changes.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent / Legal Guardian / Legal Representative: _____