LOIS CARANI, MD, FCCP
PULMONARY MEDICINE

Authorization for Use and Disclosure of Protected Health Information (PHI)

_____	_____
Patient's Full Name	**Birthdate**
_____	_____
Patient's Address	**Telephone**
_____	_____
City / State / Zip	**Last Four Digits of Social Security Number**

I hereby authorize Lois Carani, MD, LLC to receive and /or release the following Protected Health Information:

	DATE RANGE:
☐ **Entire Medical Record (ALL dates/ALL parts EXCEPT billing)**	
☐ **Most Recent 5-year History (ALL parts EXCEPT billing)**	**From _____To_____**
☐ **History and Physical**	**From _____To_____**
☐ **Office Visit Notes**	**From _____To_____**
☐ **Consultation Notes**	**From _____To_____**
☐ **Billing Statements**	**From _____To_____**
☐ **Laboratory Reports**	**From _____To_____**
☐ **Diagnostic Imaging Reports**	**From _____To_____**
☐ **Pathology Reports**	**From _____To_____**
☐ **Operative / Procedure Reports**	**From _____To_____**
☐ **Hospital Records (Admissions)**	**From _____To_____**
☐ **Emergency & Urgent Care Records**	**From _____To_____**
☐ **Other (Be very specific please and include dates)**	

_____

_____

In addition, I authorize that this release will include health information relating to the screening for and/or treatment of such conditions as HIV/AIDS (even if testing was negative), Drug/Alcohol Abuse, Mental illness , Genetic Testing.

- ☐ **I agree to the release of this information IF it is present in my medical records _____**
- ☐ **I do NOT agree to the release of medical records relating to the following _____**

Authorization for Use and Disclosure of PHI (cont.)

Purpose of Disclosure:

_____Referral to Specialist **_____Continuity of Care** **_____Worker's Comp**
_____Change of Doctor / Provider **_____Insurance Purpose** **_____Disability/Legal**
_____Personal / Other (explain)_____

This protected Health Information is to be released to / from:

_____
Name of Company/Agency/Provider/Facility

_____
Street Address

_____
City / State / Zip

I understand that:

- The exchange of protected health information in a written or electronic form is intended to enhance the coordination of my medical care and/or reduce the possibility of miscommunication through more complete and accurate communication between all providers of my medical care. *However, I am **not** required to sign this release in order to receive medical care from Lois Carani, MD, LLC or any other healthcare provider of my choosing.* **My authorization to release my PHI is STRICTLY VOLUNTARY.**

- I may revoke this authorization at ANY time by notifying Lois Carani, MD, LLC *in writing*. However, any and all protected health information that has already been released to the designated recipient(s) cannot be retracted and any fees charged for the release of that information cannot be reimbursed and/or waived.

- Lois Carani, MD, LLC is *not* responsible for the underwriting decision and/ or actions of any insurance entities that may result from my request to release my protected health information to them. These actions could include denial of claim payment, denial to issue insurance coverage (i.e. health, life, disability, long term care, et cetera) or any other such action.

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Authorization for Use and Disclosure of PHI (cont..)

- Lois Carani, MD, LLC agrees to practice due diligence to protect the confidentiality of all PHI which is transmitted to or received from other healthcare providers, healthcare plans and/or healthcare facilities.
- I understand that if I request my PHI to be sent to a private individual or other non-covered entity, that the privacy of my healthcare information under HIPAA regulations *may* no longer be protected.
- I have the right to request a copy of this form after I have signed it.
- I may obtain further information about my rights under HIPAA at www.hhs.gov/ocr/hipaa/

This Authorization to Release Protected Health Information will expire 180 days from the date of signing or on _____ (Please insert the desired date)

Patient Signature: _____ **Date Signed:** _____

Printed Name of Patient _____

Office Staff / Witness _____ **(Complete sections below ONLY IF Applicable)**

Signature of Patient Representative / Guardian _____

Printed Name of Patient Representative/ Guardian _____

Relationship of Patient Representative to Patient _____

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