Henderson Pulmonary & Sleep Medicine
Ashish Singh, MD, FCCP, D.ABSM_____
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(252) 430-7110 Fax (252) 430-8116

REQUEST for RELEASE of My CONFIDENTIAL HEALTH INFORMATION

I authorize disclosure of (all) confidential information from my medical record since _____, specifically to include the following

_____,

as well as other relevant information, which might be helpful for the purpose of my continuing medical health care.

I acknowledge that the data released MAY INCLUDE material that is protected by law. My initials next to the corresponding concern below authorize the release, if applicable, of information pertaining to

_____ Mental Health

_____ Drug & Alcohol Use

_____ HIV / AIDS and/or other Communicable Disease

_____ Genetic Testing

I may revoke this authorization at any time by presenting a written request to HP&SM's Privacy Officer. Unless revoked, this authorization shall expire 60 days from the date of signature. I understand that my information is subject to redisclosure by HP&SM, and that subsequently my private health information will no longer be protected. A copy of this agreement is valid as the signed original. Further, I understand that continued treatment at HP&SM is not contingent upon receiving this information. Fees may apply for record copies.

Please send my information to the above address. Thank you.

Signed _____ on _____(date)

(Patient or Authorized Representative & A.R's Relationship to Patient)

My date of birth is _____ witness rev.8.2007