THE LUNG CENTER

Sleep Disorders Specialists of Manatee

Michael D. Seeman, M.D. • Floyd W. Wells, M.D. • Michael W. Burke, M.D.

Pulmonary, Critical Care and Sleep Disorders Medicine

Authorization for Disclosure or Use of Protected Health Information

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's signature. *This authorization will expire 6 months from date signed.*

I hereby authorize:

_____

To disclose or use the following information from the health records of:

Name: _____
(Last) (First) (MI)

Date of Birth: _____ Last four digits of S.S.N.: _____

This information is to be used or disclosed to:

Dr.Seeman Dr. Wells Dr. Burke

Phone # (941)-792-0611 Fax # (941)-792-0086

For the purpose of (choose one): continued health care personal insurance other

Please include the following when sending records:

- Office notes - PRIOR YEAR TO PRESENT
- Pulmonary Function Test - ALL
- Arterial Blood Gas - ALL
- Electrocardiogram- ALL
- Chest X-Rays – CD's and reports
- CT Scans- CD's and reports
- Lab Work – PRIOR YEAR TO PRESENT
- Other - _____

_____

_____

*** I understand that these records may include, unless marked "Do not release", information relating to:

- HIV/AIDS diagnosis, treatment, etc.
- STD diagnosis, treatment, etc.
- Treatment for alcohol and drug use/abuse.
- Behavioral health services/ psychiatric or psychological care.

Affirmation of Release:
By signing below I give permission to the above named entity or persons to release only the information I have selected on this form to The Lung Center. I understand that I may refuse to sign this authorization. I also understand that The Lung Center cannot deny or refuse to provide treatment if I refuse to sign this authorization. I further understand that the information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal and state privacy laws. I understand that I have a right to receive a copy of this authorization if I request one.

_____ _____
Signature of patient/ legal representative Date signed

_____ _____
(If not signed by patient) print name Relationship to patient

Florida State Legislature determines the cost of records. Any payments are required prior to release.