NOVA
PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES LLC

Authorization to Disclose Protected Health Information

I authorize NOVA Pulmonary Critical Care and Sleep Associates LLC to disclose the protected health information of:

Patient Name: _____ DOB: _____
Address: _____ City/State/ZIP: _____
Phone: _____ Patient ID:_____

TO:
Name of Person or Facility:_____
Address: _____ City/State/ZIP: _____
Phone: _____ FAX: _____
Email: _____

Dates of service to be disclosed:_____

Types of documents/information to be disclosed:

_____Clinic notes _____History _____Operative/procedure notes _____lab reports
_____x-rays _____billing _____entire record _____ other _____(list)

Purpose of this request:_____

I understand that I am giving my permission to NOVA Pulmonary Critical Care and Sleep Associates LLC for disclosure of confidential health records. I understand that NOVA Pulmonary Critical Care and Sleep Associates LLC may not condition treatment or payment on my willingness to sign this Authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this Authorization. I also understand that I have the right to revoke this Authorization at any time by sending a written request to **NOVA Pulmonary Critical Care and Sleep Associates LLC at 24430 Stone Springs Blvd. Suite 345, Dulles, VA 20166**, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this Authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this Authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

Unless otherwise revoked, this authorization will expire in 90 days from the date below ***or*** on the following date, event, or condition. _____

I understand that I will receive a copy of this signed Authorization form.

I have read and understand the information in this Authorization form.

Signature of Patient or Authorized Representative:
Printed Name:
Date: **Time:**
Relationship of Authorized Representative (if applicable):