



The Institute for Respiratory and Sleep Medicine

Authorization for Release of Information

I, _____, (DOB: / /) hereby authorize the Institute for Respiratory and Sleep Medicine to disclose the following protected health information:

(Describe the information to be used or disclosed, ie. physician notes, tests results, billing information) to:

(Person or Entity information is to be released to)

This protected health information is being used or disclosed for the following purposes:

(List specific purposes here ie: treatment, insurance, legal, etc.)

This authorization shall be in force and effect until _____ (please specify expiration date for this authorization) at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Privacy Officer** at 1000 Floral Vale Blvd., Suite 125, Yardley, PA 19067. I understand that a revocation is not effective to the extent that the entity to receive the information has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

The Institute for Respiratory and Sleep Medicine will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).

I understand that I have the right to refuse to sign this authorization.

The use or disclosure requested under this authorization may result in direct or indirect remuneration to the Institute for Respiratory and Sleep Medicine from a third party (If applicable).

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative Description of Personal Representative's Authority

1000 Floral Vale Blvd
Suite 125
Yardley, PA 19067
P: (267) 759-6300
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