The Institute for Respiratory and Sleep Medicine

Authorization for Request for Information

I, _____, (DOB: / /) hereby authorize

_____ to disclose the following

protected health information to Institute for Respiratory and Sleep Medicine:

_____

(Describe the information to be disclosed, such as medical records, physician's notes, test results, insurance information, etc.)

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Institute for Respiratory and Sleep Medicine in the following manner:

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 Institute for Respiratory and Sleep Medicine 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.

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

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

_____ _____/_____/_____

Signature of Patient or Personal Representative Date

_____ _____

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

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Revised: 7/2018