PATIENT CONSENT AND AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pulmonary Sleep and Critical Care Specialists may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). Please refer to Pulmonary Sleep and Critical Care Specialists' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pulmonary Sleep and Critical Care Specialists reserves the right to revise their Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Brianne Itschner, Privacy Officer at 4235 Kings Highway, Suite 103 Port Charlotte, FL 33980.

With my consent, Pulmonary Sleep and Critical Care Specialists' may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

By signing this form, I am consenting to Pulmonary Sleep and Critical Care Specialists' use and disclosure of my PHI and to carry out TPO. I may revoke my consent in writing except to the consent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pulmonary Sleep and Critical Care Specialists may decline to provide treatment to me.

By signing this form, I also authorize Pulmonary Sleep and Critical Care Specialists to disclose my protected health information and treatment, payment and healthcare operations to the following family members and/or friends:

Name:_______________________________________ Date of Birth:___________ Relationship:_____________________

Name:_______________________________________ Date of Birth:___________ Relationship:_____________________

Name:_______________________________________ Date of Birth:___________ Relationship:_____________________

Please list any information you do not want disclosed to the above named people:

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______________________________________ ______________________________________ _________________

Signature of Patient/Legal Representative **Printed Name of Patient/Legal Representative** **Date**

Disaster Relief Efforts: We may use or disclose your health information to a public or private legally authorized or chartered disaster relief organization to coordinate in notifying a family member, personal representative, or other person(s) responsible for your care about your location, condition or death.

Patient/Legal Representative Signature: ____ **Date**: ___________________