# Pulmonary and Critical Care Specialist of Princeton, PC

## HIPAA Record Release

Patient Name: _____ DOB: _____
Social Security Number: _____

Any physician, staff, employee or representative of Pulmonary and Critical Care Specialist of Princeton, PC has my permission to discuss my account and medical conditions which may include symptoms, treatment, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Name | Relationship | Phone Number |
| _____ | _____ | _____ |
| Name | Relationship | Phone Number |
| _____ | _____ | _____ |
| Name | Relationship | Phone Number |

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Pulmonary and Critical Care Specialist of Princeton, PC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if this information is shared with the above individuals it may be subject to redisclosure by the individual(s).

By signing below, I acknowledge receiving a copy of Pulmonary and Critical Care Specialist of Princeton Privacy Practices.

Patient Signature: _____ Date: _____