KIDNEY CLINIC

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Peachtree City, GA 30269
P:(770)376-6256 F:(678)545-6872

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB_____
Address: _____City:_____State_____
Phone number: _____
Person(s) authorized to speak on my behalf: _____
Phone Number:_____

I authorize representatives from _____ to disclose the following protected health information to the following person/persons.

Please send my health information to:
Name: _____
Address: _____
City: _____State:_____
Phone Number: _____Fax Number_____

Description of Health Information to be Disclosed

- Complete Medical Record (specify dates)_____
- Partial Medical Record (specify records below)

Information to be released

	Dates
o History & Physical	_____
o Office notes/Progress notes	_____
o Consultations	_____
o Discharge Summary	_____
o Lab Results	_____
o Xrays/CT/MRI/Ultrasound	_____
o Operative Notes	_____
o Pathology reports	_____

Right and Responsibilities:

1. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization it must be done in writing and presented to Kidney Clinic. I understand that the revocation will not apply to any health information that has already been released.
2. I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.
3. I understand that the health information disclosed may include psychological information, chemical dependence, alcohol abuse, HIV status, and/or Hepatitis.
4. I understand that I am waiving any privilege concerning such information for the purpose of releasing it to the party authorized above. I release Kidney Clinic and its employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me.

_____ _____ _____
Signature of Patient (or Patient's Representative) Date Time

_____
Printed Name