Advanced
NEPHROLOGY ASSOCIATES, PC
SPECIALIZING IN NEPHROLOGY AND HYPERTENSION

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Full Name _____
Date of Birth _____ Social Security Number _____
Address _____ City/State _____ Zip _____
Home Phone _____ Mobile Phone _____

To: _____ I am or have been a patient at _____.
I understand that the facility has legally protected health information about me. I hereby authorize _____to release information to:

Name of Entity _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

The following information or copies of: **(place a check by types of records desired)**

____ The entire medical record **INCLUDING** HIV related information, behavioral health, drug or alcohol, treatment.
____ The entire medical record **EXCLUDING** HIV related information, behavioral health, drug or alcohol, treatment.
____ Lab results only
____ Diagnostic test results only
____ Office notes only
____ Billing or other business records
____ Other:
Please explain _____
_____

Reason for request: (check all that apply)

____ Continuing Treatment
____ Transferring Care
____ Insurance
____ Legal
____ Employer
____ Second Opinion
____ Other
____ I do not wish to disclose the reason

This authorization will expire in six months or _____
(date)

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Practice Administrator. I understand that recipients may re-disclose information which I have authorized them to receive.

_____ _____
Patient's or Representative's Signature Date
(If representative, give relationship and authority to act)
Witness's Signature date
(When signing by mark)

Revision10/23/18