AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: ____/____/_____

I hereby authorize the following entity to release to Partners in Nephrology & Endocrinology my protected health information:

_____
(Doctor, Hospital, Facility, Person)

_____
(Address)

_____ _____
(Phone) (Fax)

The information to be released is (select one): ☐ Entire Medical Record ☐ The Following Information:

_____

_____

The purpose for this release of information is:

☐ Complete Insurance Process ☐ Legal Reasons

☐ Personal Reasons ☐ Disability

☐ Other: _____

I understand the provision of healthcare treatment/payment is not dependent on this authorization and I am not required to sign this authorization; however the information will not be disclosed without it. I understand that if anyone who received my health information is not a health care provider or health plan, federal privacy laws may no longer protect the health information.

I understand I have the right to revoke this authorization in writing at any time, except to the extent information has already been released pursuant to this authorization at the· time of the revocation. I can revoke this authorization by sending correspondence to the manager of the facility listed above.

This authorization shall expire 90 days from the date of signature.
A photocopy is as valid as the original.

_____ _____
(Date) (Signature of patient or legal representative)

If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the patient named above and I am not prohibited by court order from releasing access to the requested information.