The Centers for Kidney Care

Authorization for Release of Protected Health Information (PHI)

Please complete all fields below for the release of PHI or Right to Access		
Patient's Name:	**Birth Date:**	**Social Security No. (optional):**

Name of the person information is being released to:	**Relationship to the Patient:**
1.	
2.	
3.	
4.	

This authorization shall remain valid until written notice is given by me revoking said authorization or unless the following information is completed below: (Fill in the date or event, but not both).

Date: Event:

Purpose of Disclosure:

___ All PHI in Record	___ Physician Orders	___ Demographics
___ History and Physical	___ Laboratory	___ Rehabilitation Services
___ Consult Report	___ Imaging/Radiology	___ Special Tests/Therapy
___ Operative Report	___ Nursing Notes	___ Itemized Bill(s)/Claim(s)
___ Progress Notes	___ Medication Record	___ Other

I acknowledge that all medical records released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____(**Initial**)

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing; but, if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorize The Centers for Kidney Care to release the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient: