Kidney Clinic

1425 Highway 34 East
Newnan, GA 30265
Tel: 770-304-3724 Fax: 770-304-3726

130 Governors Square, Suite C
Peachtree City, GA 30269
Tel: 770-376-6256 Fax: 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
History & Physical	_________________________
Office notes/Progress notes	_________________________
Consultations	_________________________
Discharge Summary	_________________________
Lab Results	_________________________
Xrays/CT/MRI/Ultrasound	_________________________
Operative Notes	_________________________
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

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Printed Name