## Nephrology Physician Services, LLC.
### AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand if the person/organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I agree a copy of this form may be treated as a signed original.

Patient Name:________________________________________SSN#______________________

Address:________________________________________________________________________

City:________________State:____________________Zip Code:_________________________

Maiden Name:__________________Date of Birth:__________Daytime Phone:______________

Person/Organization **providing** information: Person/Organization **receiving** the information:

___________________________________ ______________________________________

___________________________________ ______________________________________

___________________________________ ______________________________________

**PURPOSE OF RELEASE**: _____Attorney ____ Insurance ____Other:

***<u>SPECIFIC DESCRIPTION OF INFORMATION (dates, specify doctor, and records needed</u>***):

___History and Physical ___Discharge Summary ___Lab Results ____Medicine List

___X-rays (___Reports ___Films) ___Operative Reports ____Office Notes/Records

___EKG, Treadmill or other test results ____Other:

The information released **may** include records regarding mental health, developmental disability, alcohol or drug abuse and/or infectious diseases(including HIV,AIDS, or AIDS-related conditions) unless specifically requested **not** to include these records.

**The patient must read and initial the following statements:** **Initials**

1.I understand the records will be available within 30 days unless I am otherwise notified. _________
2. I understand I must be supervised if I am inspecting my records and there may be a fee for the supervision. _________
3. I understand this authorization will expire in 60 days. _________
4. I understand I may revoke this authorization at any time within the 60 days by notifying Nephrology in writing. This revocation will not affect any actions already completed. _________
5. There may be a fee charged for the cost of furnishing a copy or summary of the health record. _________

______________________________ ______________________________

Signature of patient Date

08/2006