Authorization for Use and Disclosure of Protected Health Information

Release Records From:_____

Release Records To:_____

Patient Identification: Name:_____ Date of Birth:_____

Address:_____

Social Security Number:_____ Phone: (H)_____ (C)_____

Information to be Released-Covering the Periods of Health Care

From: (date)_____ To: (date)_____

Please Check Type of Information To Be Released: ___Complete Health Record

Purpose of Request: ___ Treatment of Consultation ____ At request of Patient

Drug/Alcohol Abuse and/or Psychiatric, and HIV/AIDS Records Release:

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Yes**_____**No**_____

I understand if my medical or billing record contains information in reference to HIV/AIDS (human immunodeficiency virus/acquired Immunodeficiency syndrome) testing and/or I agree to its release. **Yes**_____**No**_____

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Springfield Nephrology Associates. Unless revoked, this authorization will expire on the following date,_____ or one year from date of signature, unless otherwise specified.

Re-disclosure:

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the health insurance portability act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information to extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure:

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect the protected health information to be used or disclosed.
I Authorized Springfield Nephrology Associates to use and disclose the protected health information specified above. I understand that itemized records release forms are available from Springfield Nephrology Assoicates. Any records release form signed after the date of this form revokes any authorization of this record release form.

Signature:_____Date:_____

Authority to sign if not
patient:_____Date:_____