Kidney Care Consultants, P.C.
(901) 382-5256

Authorization For Release Of Information

For information about how your medical information may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer. The Notice is also posted at Kidney Care Consultants, P.C.'s offices.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED *(such as enrollment in research study or examining you to create a report for your attorney)*.**
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.**
- **WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM.**

THIS AUTHORIZATION IS VOLUNTARY

I, _____, Date of Birth _____ do hereby authorize Kidney Care Consultants, P.C. to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to whom I authorize disclosure of my personal data and/or individually identifiable health information is not a health plan, health care provider, or clearinghouse the released information may no longer be protected by federal privacy regulations.

I authorize release of information from my medical record (as outlined below and initialed):

_____ Complete medical record that may contain treatment notes regarding radiology, pathology ***(including HIV test results and genetic testing information)***, immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2***, and other common medical record documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice.

OR

_____ For information collected/services described below and provided during the time period of _____.

Description of records to be released:_____

_____

Release my medical records to the following: (Spouse), , (Son), (Daughter)

For the purpose(s) of: Information concerning my health status

Once Kidney Care Consultants, P.C. gives out the information that I want released, I know that Kidney Care Consultants, P.C. has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal and state privacy laws may no longer protect the information.

I understand that I may withdraw my authorization in writing to the Privacy Officer at any time except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire ***one (1) year from this date*.** I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of patient's representative_____
Description of the Representative's authority to act for the patient_____

_____

This form does not have to be completed to release information for treatment payment or healthcare operations except when the information to be released contains confidential details as listed above, privileged categories or certain research information.