Cleveland Kidney & Hypertension Consultants, Inc.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patients Full Name: _____

Date of Birth: _____ Social Security Number: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

To: _____

I am or have been a patient at _____. I understand that the facility has legally protected health information about me.
I hereby authorize _____ to release information to:

Name of Entity _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

The follow information or copies of **(place a check beside types of records desired)**

_____ The entire medical record **INCLUDING** HIV related information, behavior health, drug or alcohol treatment

_____ The entire medical record **EXCLUDING** HIV related information, behavior health, drug or alcohol treatment

_____ Lab Results Only

_____ Diagnostic Test Results Only

_____ Doctor's Office Notes Only

_____ Billing or Other Business Records

_____ Other: Explain _____

_____

Reason for Request: **(check ALL that apply)**

_____ Continuing Treatment

_____ Transferring Care

_____ Insurance

_____ **Legal**

_____ Employer

_____ Second Opinion

_____ Other

_____ I do not wish to disclose a reason

This authorization will expire in six months or _____. (Date)

A photocopy or facsimile of the authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Practice Administrator. I understand that recipients may disclose information I have authorized them to receive.

_____ _____

Patient's or Representative's Signature **Date** **Witness' Signature** **Date**

(If representative, give relationship and authority to act)