AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)						
Name				Phone		
Address						
City/State Zip	City		State		Zip	

RECORDS FROM: (Who is **Releasing** the Records)						
Name	Desert Kidney Associates			Phone	480- 834 - 9039	
Address	612 W Baseline Road			Fax #	480 - 964 - 7802	
City/State Zip	City	Mesa	State	AZ	Zip	85210

For the Following Purposes:

☐ Continued Medical Care	☐ Personal Information	☐ Legal Follow-up
☐ Disability Insurance	☐ Other:	

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

☐ Please send the entire Medical Record (all information) to the above named recipient.		
☐ Office Notes and Reports	☐ Diagnostic Reports	☐ Billing Statements
☐ Rx History	☐ Transcribed Hospital Reports	☐ Laboratory Reports
☐ Others Listed Here:		

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

____☐ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

____☐ Mental Health Information and/or Records

____☐ Domestic Violence

____☐ Genetic Testing Information and/or records

____☐ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

_____☐ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____