AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Physician or facility to provide records: _____

Patient's Name: _____

Social Security #: _____

Person/facility to receive records: _____

_____

_____

Release these records: *Initial One*

1) Only records generated by this facility (not including records received from other sources) _____
2) Only some portion of records maintained at facility (dates of treatment, etc., specify below)_____
3) All medical records at this facility. _____

_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the **EXCEPTION** of:

Initials		*Initials*	
_____	Substance abuse, if any	_____	AIDS/HIV if any
_____	Psychological or psychiatric conditions		
_____	Other (please specify): _____		

Expiration or revocation of authorization ~~ I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original.

Patient's name (print): Person authorized to sign for patient:

_____ _____

_____ _____

Patient's Signature Signature

_____

Relationship to Patient

Date: _____

NEPHROLOGY & HYPERTENSION SPECIALISTS, P.C.
PATIENT AUTHORIZATION

I, _____, authorize the use and/or disclosure of my health information as set for below:

1) The following health information may be used and/or disclosed pursuant to this authorization: _____
   _____
   _____

2) I authorize the following person(s) to make the requested use disclosure of my health information:_____
   _____
   _____

3) I authorize the following person(s) or class of person(s) to receive my health information:
   _____
   _____
   _____

4) This authorization expires: _____

5) I understand that I have the right to revoke this authorization at any time, except to the extent that the person(s) or class of person(s) to whom I have authorized such use and/or disclosure have acted in reliance upon this authorization. In order to revoke this authorization I must provide NEPHROLOGY & HYPERTENSION SPECIALISTS, P.C. in writing specifically revoking this authorization.

6) I understand that my health information may no longer be protected by the federal privacy protection regulations, 45 C.F.R. parts 160 and 164 if my health information is used or disclosed pursuant to this authorization.

7) I have/do not have (*circle one)* an Advance Directive (Living Will, Health Power of Attorney). Copies can be made available upon request.

_____ _____

Signature of individual or personal representative Date

I authorize the release of my medical records to:

Nephrology and Hypertension Specialists
1506 Broadrick Drive
Dalton, GA 30720

Telephone: 706-278-3430

Fax: 706-370-4859

Please send a copy of any pertinent medical records, i.e. progress notes, labs, x-rays, EKG results, H&P etc.

SIGNATURE OF PATIENT:

_____

DATE:

_____

Nephrology & Hypertension Specialists, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name and Address:

_____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature of patient or patient's representative Date

_____

Name of patient or patient's representative

_____

If applicable, relationship to patient

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:
  _____
- ☐ Other: _____
  _____

Prepared By: _____

Signature: _____