METROLINA
NEPHROLOGY ASSOCIATES

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ DOB _____ MR# _____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

( ) problem list ( ) medication list ( ) list of allergies

( ) immunization record ( ) latest history and physical: date_____

( ) consultation reports: dates_____ doctor_____

( ) latest discharge summary: hospital and date_____

( ) laboratory results from (date) _____ to (date) _____

( ) x-ray/ imaging reports from (date) _____ to (date) _____

( ) entire record to date ( ) Other_____

FOR THE PURPOSE OF: _____

Please send this information:

TO: _____ FROM: _____

_____ _____

_____ _____

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the MNA Privacy Officer or his/her designated person. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____.
5. If I fail to specify an expiration date, event or condition, this authorization will expire in six months. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the MNA Privacy Officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If signed by Legal Representative, Relationship to Patient Signature of Witness