ASSOCIATES IN NEPHROLOGY

7981 Gladiolus Drive, Fort Myers, FL 33908

Authorization for Disclosure or Use of Protected Health Information and Acknowledgement of Receipt of Privacy Practices

I have been presented with a copy of this practices *Notice of Privacy Practices*, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restrictions concerning the use of my personal medical information:

1. May we contact you by telephone as described in our Notice of Privacy Practices? YES NO

2. May we leave a message on message on your machine or with any household member? YES NO

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be inapplicable or specifically not authorized for release. This release is not valid if it does not contain the patient's signature and date signed or if it has expired as described below.

I hereby authorize: **ASSOCIATES IN NEPHROLOGY PROVIDERS, 7981 Gladiolus Drive, Fort Myers, Florida 33908**
To disclose or use the following information from the health records of:

Your Name: _____ _____ _____
Last/First/Middle Initial | Date of Birth | Social Security Number

This information can be used or disclosed to (NAME of provider(s), entity, family members, friends or class of persons):

Referring Physician: _____ Phone_____

Primary Physician: _____ Phone_____

Physician: _____ Phone_____

Physician: _____ Phone_____

Name: _____ Relationship: _____ Phone_____

The following information may be disclosed or used (please check all that apply):

____The entire medical record*

____ Medical records related to: *
Specific condition(s) _____
Specific date(s) of service_____
Specific test(s) _____
____ Records from a specific doctor: *
All records from doctor(s) _____
Specific records from doctor(s) _____
Specifically: _____

**I understand that these records may include information relating to: Acquired immunodeficiency syndrome (AIDS) / human immunodeficiency virus (HIV), or Sexually transmitted diseases, or Treatment for alcohol and/or drug abuse, or Behavioral health service/psychiatric care.*

Affirmation of Receipt of Privacy Practice and Release:
By signing below, I acknowledge that I have received the *Notice of Privacy Practice* **AND** I give my permission to the above-named entity or class of persons to release only the information I have selected on this form to the entity or class of persons I have named. I understand that this release is valid up to one year from the date I signed and that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. Revocation must be made in writing and given to this office. I understand that I may refuse to sign this authorization. I understand that Associates in Nephrology cannot deny or refuse to provide treatment/payment if I refuse to sign this authorization. I understand that the information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal and State privacy laws. I understand that I have a right to receive a copy of this authorization if I request one.

_____ _____
Signature of Patient – OR Guardian/Legal Representative | Date Signed – (Not valid for more than one year)