Mid-Atlantic Nephrology Associates, P.A.®

Authorization For Use or Disclosure of Protected Health Information

Please Complete the Following Patient Information

*Name:*_____

Address: _____

_____

Phone: _____

Social Security Number: _____*Date of Birth:*_____

People we may contact regarding your Protected Health Information:

- ☐ *Anyone who answers my home telephone*_____
- ☐ *Home telephone with voice mail/answering service*_____
- ☐ *Work telephone with voice mail*_____
- ☐ *Cell phone with voice mail*_____
- ☐ *Full name and relationship to you of anyone else who may receive my Protected Health Information:*

  _____

  _____

  _____

Description of Information to be Released or Disclosed (check all appropriate)

- ☐ *Lab results*
- ☐ *X-rays*
- ☐ *Diagnostic testing results*
- ☐ *Medical records*
- ☐ *Other (please specify):*_____

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This authorization shall expire no later than:_____/_____/_____ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature for Maryland medical records.

By signing below I represent and warrant that I have authority to sign this document. I authorize the use or disclosure of protected health information.

There are no claims or orders pending that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic disease, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIV/AIDS), and/or genetic marker information. These records will be included in the information we will make available to the individual or organization you have identified above, and to whom you are authorizing disclosure of this information. In addition, the information to be disclosed may be protected by law. Information disclosed under this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.

I may revoke this authorization at any time by notifying the Practice. However, revoking this authorization will not have any effect on the authorization before the Practice received notice of your revocation. I may request a copy of this form.

My ability to receive health care treatment from the Practice will not be affected if I do not sign this form. However, without my signature, my request for release of information listed above will not be honored.

Signature of Individual or Individual's Representative

(If signing as a personal representative for a patient, you must provide written documentation that you are authorized to sign for the patient.)

_____ *Date:*_____

Signature of patient
(or Patient's legal representative)

_____ *Date:*_____

Printed name of patient
(or Patient's legal representative)

_____

Relationship to the individual, including authority for status as representative