SNOWY RANGE KIDNEY CARE

Authorization for the Use and Disclosure of Protected Health Information

PATIENT INFORMATION

Patient Name: _____

Patient Address: _____

Patient SSN: _____ **Date of Birth:** _____

Maiden/Other Name: _____ **Phone Number:** _____

INSTRUCTIONS

I authorize **Snowy Range Kidney Care** *to release my medical records for the service dates* _____ *to* _____

For the following purpose: ☐ *At My Request (patient only)* ☐ *Continuation of Care* ☐ *Insurance* ☐ *Legal* ☐ *Other*

Release to: Name _____

Release to: Address _____

Please release the following information in my medical record (check all that apply):

☐ *Entire Medical Record*	☐ *History and Physical*	☐ *Med Sheets*	☐ *Other:* _____
☐ *Medications*	☐ *Laboratory Reports*	☐ *Progress Notes*	_____
☐ *Radiology*	☐ *Billing Records*	☐ *Consultations*	_____

SPECIAL INSTRUCTIONS

Check one: ☐ **Yes** ☐ **No** *I understand that the records used and disclosed pursuant to this authorization may include information relating to treatment or diagnosis of: Human Immunodeficiency Virus ("HIV") infection, Acquired Immunodeficiency Syndrome ("AIDS") or other sexually transmitted diseases; Hepatitis B&C; history of drug or alcohol abuse; or mental or behavioral health or psychiatric care; and/or other sensitive information. I authorize the release of the above listed information with the request.*

ACKNOWLEDGEMENT

This authorization will expire upon discharge from SRKC. I understand that this authorization is voluntary and may be revoked by me at any time in writing except to the extent that action has already been taken in reliance with this authorization. I understand that SRKC may not condition my treatment upon my authorization of this disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and will no longer be protected by HIPAA.

_____
Signature of Patient or Patient's Representative
(Personal & Legal Representative must include proof of status)

☐ *Parent*
☐ *Personal Representative*
☐ *Legal Representative*

_____
Date

_____
Printed Name of Patient or Patient Representative

FOR SRKC STAFF ONLY:
☐ *Identity Confirmed by SRKC Staff*

Printed Name of Employee: _____

Signature of Employee: _____ *Date:* _____