Authorization for Disclosure of Health Information

Patient's name _____ Birth Date _____

Street Address _____ City, State, Zip Code _____

I hereby authorize:

Name _____

Street Address _____

City, State, Zip Code _____

To disclose my PHI as described below to:

Name of Individual/Entity _____

Street Address _____

City, State, Zip Code _____

Purpose of release (ex. Continued care, personal, etc.) _____

Information to be released:

- ☐ History & Physical/Progress Note
- ☐ Radiology/X-Ray Reports
- ☐ Laboratory/Pathology Reports
- ☐ Hospital Reports
- ☐ Surgical Reports
- ☐ Prescriptions
- ☐ Allergy
- ☐ Other _____

☼This authorization is for the release of medical records and information including diagnosis, treatment, and/or examination related to mental health, drug and/or alcohol abuse, HIV testing/AIDS and sexually transmitted diseases.

☼As required by the State of Florida and federal law, Nephrology Associates of Lake County, LLC/employees may not use or disclose your health information, except as provided within the Health Insurance Portability and Accountability Act (HIPAA), without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

☼I understand that state law prohibits the re-disclosure of the information disclosed to persons/entities listed above without my further authorization, but that Nephrology Associates of Lake County, LLC/employees cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

☼I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to: 3801 N. Hwy 19A, Ste 400-Mt. Dora, FL. 32757. I further understand that any such revocation does not apply to information already released in response to this authorization.

☼I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.

☼I understand that I have a right to inspect and to obtain a copy of any information disclosed.

☼I hereby release Nephrology Associates of Lake County, LLC/employees from any and all liability that may arise from the release of information as I have directed.

☼I hereby authorize Nephrology Associates of Lake County, LLC/employees to release health information as described above.

Signature of Patient (or Legal Representative) _____ Date _____

Relationship to Patient _____