SAN ANTONIO KIDNEY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use or disclosure of protected health information from medical record of:

Patient Name: _____ Date of Birth: _____

I authorize San Antonio Kidney to release protected health information about me, by releasing a copy of my PHI, providing a summary or narrative of my PHI, or verbally to the individual(s) or organization listed below.

I specifically authorize the use and disclosure of the following PHI:

A. Authorization for release of PHI covering the period of health care (check one):

☐ From Date _____ to _____ OR

☐ All past, present and future periods

B. I hereby authorize the release of PHI as follows (check one)

☐ My complete health record (including records relating to mental health, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR

☐ My complete health record with the exception of any checked below

- ☐ Mental health records
- ☐ Communicable disease (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

Authorization for release of Protected Health Information (PHI) regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

I understand that I have the right to revoke this authorization at any time in writing. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

SIGNATURE: _____ DATE: _____