



Authorization for Release of Protected Health Information (PHI)

I hereby authorize Fort Worth Renal Group to release health records information on:

Patient Name, Address, City/State/Zip, DOB, Phone, SS#, For Healthcare Covering the Period(s) from to

- May records be faxed or electronically transmitted? Yes No

This information is to be released to:

Name of person/facility to receive information, Telephone #, Fax #

Address of person/facility to receive information, City, State, Zip

Information to be disclosed: (Please initial on appropriate line.)

Copy of all health records to include HIV testing/results, mental health and/or alcohol or drug abuse records
Copy of all health records to exclude HIV testing/results, mental health and/or alcohol or drug abuse records
Billing Records
Specific records: Laboratory Tests Progress Notes X-Ray Reports Other

It is preferable to request patients and third parties to indicate what specific parts of the record need to be disclosed so as to meet the HIPAA Privacy Rule minimum necessary standard.

The purpose of this disclosure is for: Continuation of Medical Care Attorney Insurance Other

I understand that the information released as a result of this Authorization may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider. I understand that this Authorization may be revoked in writing at any time.

I understand that revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indicated, this authorization will expire twelve months (12) from the date of signature. A photocopy of this authorization will be considered as valid as the original.

I understand and agree that my medical record will be maintained in an electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system.

I understand that FWRG cannot require me to sign this Authorization as a condition to providing services to me. I understand disclosure is voluntary. I understand that if I have any questions about this disclosure, I may contact my physician or FWRG Privacy Officer.

Signature

Date

(Relationship or status if signed by anyone other than patient, parent or legal guardian, personal representative, etc)