KIDNEY ASSOCIATES OF TEXAS

Excellence in kidney care

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Authorization for Release of Medical Records / PHI

Patient name _____ **Date of birth** _____

Address _____ **Phone** _____

1. RECORDS TO BE RELEASED FROM

Provider / facility _____

Address _____ **Phone / fax** _____

2. RELEASE RECORDS TO

Person / facility _____

Address _____ **Phone / fax** _____

Secure email (if applicable) _____

3. INFORMATION TO BE DISCLOSED

[ ] Complete medical record [ ] Progress notes [ ] Laboratory results [ ] Imaging reports

[ ] Medication list [ ] Billing records [ ] Other: _____

Date range: _____ **to** _____ **[ ] All dates**

4. SENSITIVE INFORMATION

Unless I limit the authorization below, I understand that the records released may include information protected by federal or state law. Where a separate or more specific authorization is legally required, the practice may ask me to complete it before releasing those records.

I specifically authorize release of the following, if present and if permitted by law:

[ ] HIV / AIDS information [ ] Mental health information [ ] Substance use disorder records

[ ] Genetic information [ ] Other sensitive information: _____

5. PURPOSE OF DISCLOSURE

[ ] Continuation of care [ ] Personal use [ ] Insurance [ ] Legal [ ] Other: _____

6. EXPIRATION AND MY RIGHTS

This authorization expires 12 months after the date I sign it unless I write a different expiration date or event here: _____. I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it.

I understand that signing this authorization is voluntary. Kidney Associates of Texas generally will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization, except where permitted by law. Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by HIPAA or other privacy laws.

7. DELIVERY METHOD

[ ] Fax [ ] Secure electronic transmission [ ] Mail [ ] Pick up [ ] Other: _____

8. SIGNATURE

By signing below, I authorize the release described above and confirm that I understand this form.

Patient / authorized representative signature _____ **Date** _____

Printed name of representative (if applicable) _____

Relationship / authority _____

Please do not send protected health information by ordinary email. For questions, call 972-521-6000.