Authorization for Use or Disclosure of Protected Health Information

Name: _____ Date of Birth: _____ Social Security Number: _____

Address: _____ Phone Number: _____

This authorization allows Victoria Kidney & Dialysis Associates to:

_____ **SEND** _____ **RECEIVE** copies of my records to (or discuss my information with) the provider/person/facility below

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

Treatment Dates: _____ Purpose of Request: _____

Please check all that apply:

____ Physician Notes
____ Lab Results
____ Radiology Reports
____ Biopsy Results
____ Complete Record to include the following information: ___Alcohol and Drug Abuse ___HIV/AIDS ___Mental and Behavioral Health ___Genetics
____ Other: _____

***Psychotherapy notes require a separate authorization and will not be released under this authorization.**

Notice Regarding Sensitive Information:

I understand that the information in my record may include information relating to Acquired Immune Deficiency Syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about treatment for alcohol and/or drugs, behavioral or mental health service, or genetic information.

Notice Regarding Re-Disclosure:

I understand that any information released or disclosed under this authorization at any time is subject to re-disclosure by the receiving party, and may no longer be protected by federal privacy rules.

Right to Revoke:

I understand that I have the right to revoke this authorization at any time. This revocation must be submitted in writing. I further understand that the revocation will not apply to information already based on this authorization.

Expiration:

Unless otherwise revoked, this authorization will expire in 90 days. Upon expiration, my health information can no longer be used for the purposes as outlined in this authorization without first obtaining a new authorization form. **Expiration Date: _____**

Other Information:

I understand that authorizing the disclosure of this health information is voluntary, and is not a condition of treatment or payment. I further understand that I may inspect a copy of the information to be disclosed. Should I wish to access this information, this request must be made in writing. I will be responsible for all reasonable copying, postage and preparation cost.

_____ _____ _____

Signature of Patient or Patient's Representative | Representative's Relationship | Date