## Authorization to Disclosure of Protected Health Information To Family and/or Other Authorized Individuals

l,	, give Victoria Kidney &	& Dialysis Associates authorization to relea	se the
following protect	ted health information to the person(s)	named below. I understand this office is r	ot
responsible for re	e-disclosure upon release under this aut	thorization. I further understand this autho	orization is
voluntary, and no	ot a requirement for obtaining treatmer	nt. However, if not signed, information wil	ll only be
disclosed to the	patient.		
I DO NO	OT give authorization for my protected heal	th information to be released to anyone other	than myself.
		·	·
YesNo	Test and procedure dates		
YesNo	Results of tests and/or procedures		
YesNo	Appointment dates and times		
Yes No	Acknowledgment of patient's present	ce in office	
Primary Contact	Person:	Phone Number	
		Filone Number	
	Relationship to Patient	Alternate Number	
Second Contact:			
		Phone Number	
Third Contact:			
		Phone Number	
Dationt or Dation	t's Donnesontative Cignoture		
Patient of Patien	t's Representative Signature	Date	
Representative's	Authority		
	, , , , , , , , , , , , , , , , , , , ,		
This authorizatio	n is valid until revoked in writing by pat	ient or authorized representative.	
Date	Employee Initials		