HYPERTENSION &
KIDNEY
Associates of Middle GA

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AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION (PHI)

PATIENT INFORMATION: Please type or print

I hereby authorize ______________________________ to release healthcare information on:
(NAME OF PROVIDER)

PATIENT NAME: ______________ **DATE OF BIRTH** ______________
PHONE: (H): ______________ **PHONE (W)** ______________
ADDRESS ______________ **CITY/STATE/ZIP** ______________

DATES AND TYPE OF INFORMATION TO DISCLOSE

- ☐ 2 Years prior from last date seen
- ☐ Dates other: (Please specify)______________
- ☐ Specific information requested
- ☐ May include other healthcare provider records ☐Yes ☐No
- ☐ May records be faxed/electronically transmitted ☐Yes ☐No

THE PURPOSE OF DISCLOSURE IS

- ☐ Continuance of Medical Care
- ☐ Change of Insurance or physician
- ☐ Attorney
- ☐ Other ______________

THIS INFORMATION MAY BE DISCLOSED OR USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION

NAME OF PERSON/FACILITY TO RELEASE TO: ______________
ADDRESS ______________
CITY/STATE/ZIP ______________
TELEPHONE #: ______________ **FAX #:** ______________

☐ Please Mail Records ☐ Please Fax Records

ACKNOWLEDGEMENT

I understand this authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above

I understand that there may be a fee for copying records if it is used for other than continuance of healthcare with another provider

I understand that when this information is used or disclosed, pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.

I understand that the requested health information may contain information regarding mental and physical illness, HIV test results or diagnosis, treatment of AIDS/AIDS related conditions, and/or alcohol drug abuse.

X ______________ ______________
Signature of Patient/Parent/ Guardian or authorized representative **Date**
(Guardian or authorized representative must attach documentation of such status)

______________ ______________
Printed name of authorized representative Relationship/Capacity to patient

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Address and Telephone number of authorized representative