Authorization for Disclosure of Protected Health Information
Carroll County Nephrology, PC

To the following person or class of persons: To any and all physicians health care providers, health care facilities, or healthcare entities that provide or have provided health care services to the patient named below.

Patient name _____ Date of birth: _____

Note: "You" refers to the person(s) to whom this authorization is directed. "I", "me" refers to patient.

Authorization

You are hereby authorized to disclose my protected health information, whether oral, written or electronic healthcare information pertaining to my complete medical record, including but not limited to HIV and AIDS confidential information.

You are hereby authorized to disclose my protected health information specifically pertaining to my mental health, including but not limited to psychiatric and psychological information, drug and alcohol abuse treatment information.

You are hereby authorized to disclose my protected health information to any physician health care provider or healthcare facility that has provided health care services to me. Additionally, you are hereby authorized to disclose such protected health information to any attorney at law representing such physician, healthcare provider or healthcare facility.

Discussion related to my care. You are hereby authorized to discuss my care and treatment with any attorney or representative of an insurance provider if I assert a claim against another physician, health care provider, health care facility or health care entity.

This authorization expires in three (3) years after the date of execution shown below.

I hereby authorize and direct payment to Carroll County Nephrology, PC for medical benefits under the terms of my insurance. I hereby authorize the release of medical records to the indicated insurance company9ies) for the purpose of proof of treatment, verification of coverage and pre-certification.

Patient's Rights

I understand I do not have to sign this authorization to receive healthcare benefits (treatment, payment or enrollment) from the person (s) to whom this authorization is directed. I may revoke this authorization in writing at any time. If I do so, it would not affect any actions already taken by someone in reliance on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance coverage. If I wish to revoke this authorization, I shall do so by sending a letter to the person (s) to whom this authorization is directed. Once the health care provider discloses information, any person or organization that receives it may re-disclose it. Patient privacy laws may no longer protect that information. I must sign an authorization form to take part in a research study, or to receive healthcare when the purpose is to create health information for a third party.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed Name (*if signed on behalf of patient*) **Relationship (parent, guardian, etc.)**