3175 Citrus Tower Blvd Clermont, FL 34711 PH: (352) 240-3812 | FAX: (888) 716-2003
131 Webb Dr, Suite C Davenport, FL 33837 PH: (863) 226-4676 | FAX: (888) 716-2003

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_________________________ ________ _________________
Patient Name DOB Social Security #

I hereby authorize Advanced Kidney Care of Central FL, PA and its agents/employees to
_____ RELEASE or _____ OBTAIN (please initial in appropriate space) information and copies of records pertaining to my medical care and treatment. **By state law you must be advised that the information you authorize for release may include information that could be considered information about communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome).** In addition, it may include information about mental health, or drug, substance or alcohol abuse.

Release to:

[ ] Advanced Kidney Care of Central FL, PA
3175 Citrus Tower Blvd
Clermont, FL 34711
Ph: (352) 240-3812
(863) 226-4676
Fax: (888) 716-2003

[ ] ___________________________
Name
____
Address
____
City, State Zip
____
Phone Fax

Obtain from:

____
Name
____
Address
____
City, State Zip
____
Phone Fax

Information to be Released:
_____ All medical records
_____ Most recent 2 years of pertinent information (Notes, Labs, Imaging, Special Tests)
_____ All medical billing records
_____ Other (specify)

Purpose for which request is being made. Please check one of the following:
___ Physician ___ Medical Claims Processing ___ Self ___ Attorney ___ Other

Drug/Alcohol Abuse Treatment Records:
This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rule prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rule restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

My Rights:
I understand that I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in this office. I understand that Provider has no control over any information and records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information or records may occur by such other party.

I release Provider, its employees and agents from any liability in connections with the use or disclosure of the information and records released to any party pursuant to this Authorization.

This authorization will expire in 12 months or _________________.

____________________________________ ____________
Signature of Patient/Patient's Authorized Representative Date

____________________________________ ______________
Printed Name Relationship to Patient