Colorado Kidney Care
Where Quality Comes to Life

Authorization Form for Release of Medical Records

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that the Practice cannot share your Protected Health Information (PHI) without your permission, except in certain situations. For example, your PHI can be shared without your permission if it is used to facilitate your healthcare treatment, payment, or for healthcare operations. By signing this form, you are giving us permission to share your PHI as you indicate below. I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that treatment, payment, enrollment or eligibility for benefits will not depend in any way on whether or not I sign this authorization. I further understand that I may inspect and copy any information disclosed pursuant to this authorization, and that I will receive a copy of this form upon signing it if the Practice is soliciting my signature. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed below and no longer protected. I understand that this authorization is voluntary and may be revoked at any time by signing the revocation section of my copy of this form and returning it to the Practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted up my previous authorization(s).

I hereby authorize the use and/or disclosure of my PHI as described below:

Patient Name:_____ **Date of Birth**:_____

Persons/Organization(s) to release the information: _____

_____

Persons/Organization(s) to receive the information: _____

_____

Specific Description of information to be disclosed or used (include applicable dates):_____

_____

What is the purpose of the requested use or disclosure? _____

_____

Expiration of Authorization: _____

Patient Signature:_____**Date**:_____

Revocation Section:
I hereby revoke this authorization, effective_____/_____/_____.
Patient Signature:_____ Date:_____
Printed Name of Patient:_____