TIDEWATER KIDNEY SPECIALISTS, INC.

BOARD CERTIFIED IN INTERNAL MEDICINE AND NEPHROLOGY

Authorization for Disclosure of Protected Health Information

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

I. I hereby authorize Tidewater Kidney Specialists, Inc. to disclose my health information to the following physicians, relatives and/or friends.

1. _____
   Name Relationship
2. _____
   Name Relationship
3. _____
   Name Relationship
4. _____
   Name Relationship

II. Purpose of disclosure:

____patient requested disclosure ____other:_____

III. Information to be disclosed:

____complete health record(s) ____discharge summary
____history and physical examination ____progress notes
____consultation reports ____laboratory tests
____x-ray reports ____billing inquiries
Date(s) of information to be disclosed (year, all, range):_____

IV. I understand that this will include information relating to (check if applicable):

____AIDS/HIV status ____treatment for alcohol and/or drug abuse
____behavioral health service/psychiatric care

V. Expiration date or event. This authorization will expire on the following date or event (if no expiration date is provided, this authorization will expire one (1) year from the date this authorization was signed by the patient). __
_____

I hereby authorize the use or disclosure of my protected health information as described above. I understand that this authorization is voluntary. I understand that my ability to obtain treatment or payment for treatment will not be affected if I do not sign this form. I understand that if the person authorized to receive the information is not a required to comply with the federal privacy protection regulations, then such information may be redisclosed and will no longer be protected under HIPAA. I understand that the information to be released may include records related to behavior and/or mental health, alcohol and drug abuse treatment, HIV/AIDS, and genetics. I understand that I have a right to revoke this authorization by sending written notification to: Tidewater Kidney Specialists, Inc., 4560 South Boulevard, Suite 202, Virginia Beach, VA 23452, Attn: Privacy Officer. Any revocation will not affect disclosures made prior to the Practice's receipt or knowledge of the revocation. I understand that I have a right to inspect and receive a copy of the information described on this form. I agree to waive all claims against the Practice and its physicians and employees for release of the requested information.

Signed:_____
(patient or legal representative) (date)

Print Name:_____

Relationship to Patient (if applicable):_____

Revised: September 20, 2013