NORTHERN FLORIDA KIDNEY CARE
by NPS

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Authorization to Release Protected Health Information

PATIENT'S NAME:_____ **DOB:**____/____/____

I hereby authorize Nephrology Practice Solutions

d/b/a. Northern Florida Kidney Care, to disclose my protected health information to:

_____
(Doctor, Hospital, Facility, Person)

_____
(Address and Phone)

The information to be released is: ☐ Entire Medical Record -or- ☐ The following information:

_____

_____

The purpose for this release of information is:
☐ Complete insurance process ☐ Legal reasons ☐ Personal reasons ☐ Continuity of care

☐Other _____

I understand the provision of health care treatment is not dependent on this authorization and I am not required to sign this authorization; however the above protected health information will not be disclosed without my signature on this authorization. I understand that if anyone who receives my protected health information is not a health care provider or a health plan, federal privacy laws may no longer protect my protected health information.

I understand I have the right to revoke this authorization in writing at any time, except to the extent my protected health information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by sending correspondence to the Manager of the practice listed above.

This authorization shall expire 90 days from the date of signature.
A photocopy is as valid as the original.

_____ _____
(Date) (Signature of Patient or Legal Representative)

If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the patient named above and I am not prohibited by court order from releasing access to the requested protected health information.

_____
(Signature of Parent or Legal Representative)