RENAL ASSOCIATES, P.A.

Initials	Authorization for Release of Medical Records

I hereby request/give permission to physicians and/or staff to release the following specific medical information by all medical sources for the purpose of diagnostic, insurance, legal, continuity or care and medical treatment:

- ☐ AIDS/HIV
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Office/Progress Notes
- ☐ Mental Health
- ☐ Substance Abuse
- ☐ Operative Reports
- ☐ Lab Results for dates: _____
- ☐ X-Ray Reports: _____
- ☐ Other: _____

_____ for _____ (full patient name and date of birth) to the following individuals/organizations:

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

I understand that this release is subject to revocation in writing at any time except to the extent that action has been taken. If written revocation is not received, authorization will be considered valid for a period of time not to exceed one (1) year from the date of signing. I understand that a photocopy of this authorization is valid. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.

Initials	Consent for Treatment

_____ As an adult and/or legal guardian, I agree to permit the physicians and/or clinical staff at Renal Associates, P.A., to provide medical care to myself, my child, or the patient I represent as applicable. By signing below, I agree to permit the physician and/or clinical staff to perform necessary or appropriate medical care including physical examinations, diagnosis, and treatment.

Initials	Assignment of Benefits

_____ I hereby authorize payment directly to Renal Associates, P.A., for medical benefits otherwise payable to me. I authorize my insurance company and/or the social security administration (Medicare) to disclose to Renal Associates, P.A., information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third party payor.

Initials	Notice of Privacy Practices Acknowledgment

_____ I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and treatment information to my bill, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that the organization reserves the right to change their notice and practices, and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon.

I have read the Authorization for Release of Medical Records, Consent for Treatment, Assignment of Benefits, and Notice of Privacy Practices.

Patient Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____ Date: _____

Relationship to Patient: _____ Date: _____

Witness Signature: _____ Date: _____

FOR OFFICE USE ONLY

Unable to obtain signature(s) because:
- ☐ Patient refused
- ☐ Patient has asked to take the paperwork home to read, sign, and return to Renal Associates, P.A.