TEXAS KIDNEY SPECIALISTS, P.A.

RELEASE OF INFORMATION

PATIENT NAME: ____

PATIENT DATE OF BIRTH: ____

I understand and authorize the individual or business listed below as "Entity 1" to release my protected health information to the individual or business listed below as "Entity 2".

Entity 1	Party to Release Information
Name	

Entity 2	Party to Receive Information
Name	

Method of Release	☐Fax - ______________________________ ☐In Person - _________________________
Information to be released	
Information needed for reason	

SIGNATURE AUTHORIZATION:

By signing below, I understand the following:

- I may revoke this authorization at any time by sending a written revocation to the person/organization listed above. I understand that the revocation will not apply at any health information previously disclosed in reliance of this authorization.
- Any treatment, payment or enrollment in any health plan, or my eligibility for benefits will not be affected if I do not sign this authorization.
- Any information disclosed by this authorization to any person/organization not a health care provider, business associate or health plan covered by federal or state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.
- I am entitled to receive a copy of this signed authorization

Patient Signature: ______________________________ **Date**: _________________________