Peninsula Nephrology Associates, P. A.
1821 Sweetbay Drive, Suite 1
Salisbury, Maryland 21804
Phone: 410-546-4427 Fax: 410-546-2096

Authorization to Release Protected Health Information

Name (First, Middle, Last)	**Date of Birth**	**SSN**

Release Information To

□Peninsula Nephrology Associates, P. A.
□Other (Specify healthcare provider/facility/company/individual including phone/fax if known)

Release Information From

□ Peninsula Nephrology Associates, P. A.
□ Other (Specify healthcare provider/facility/company/individual including phone/fax if known)

Purpose of Release

□ Treatment/Continued Care □ Personal □ Legal Purposes □ Disability Determination
□ Payment of Insurance Claim □ Other:

Information To Be Released (Required – check all that apply)

□ Clinical Notes	□ Hospital Discharge Summary	□ Lab Reports
□ Radiology Reports	□ History & Physical□ EKG'S	□ Operative Notes
□ Radiology Images	□ Hospital Notes	□ Immunization Records
□ Pathology Reports	□ Billing	□ Other

My Rights

I understand that authorizing the disclosure of my health information is voluntary. I understand that I do not need to sign this form in order to assure treatment or payment. I may be charged for copies in accordance with state law. I understand that this authorization may include release of the following sensitive medical information unless I have initialed below to exclude such information:

_____- mental health information ____ - sexually transmitted diseases
_____- alcohol and/or drug abuse treatment ____ - AIDS/HIV treatment

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. I understand that I do have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to provider and/or facility releasing the information.

By signing, you agree that you understand and accept the terms of this form. If the patient is incapable of signing, a legally authorized substitute may sign and date the form with proper documentation.

Signature: _____ Date(required)_____

Printed Name of Person Signing(if not the patient) please indicate legal authority:

Name:_____ Date(required)_____