RENALCARE ASSOCIATES, S.C.

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Patient's Name: _____ Date of Birth: _____

Consent for release of information:

Please list below those with whom we can discuss your medical care. Please list their name and relationship to you (i.e. spouse, child, parent, all physicians).

_____ _____

Name/Relationship & phone # Name/Relationship & phone #

_____ _____

Name/Relationship & phone # Name/Relationship & phone #

_____ _____

Name/Relationship & phone # Name/Relationship & phone #

Authorization for Release of Information:

____ ***My*** ____ ***My child's*** Medical records and information pertaining to my/his/her medical history, mental or physical condition, services rendered, or treatment.

____ ***The medical records and information belonging to this patient for whom I have authorization/power of attorney/guardianship*** (copy of authorization to be attached) pertaining to his/her/my medical history, mental or physical condition, services rendered or treatment.

This authorization is limited to the following medical records and type of information:

___ Demographics ___ Medical History ___ Services rendered

___ Insurance information ___ Physical exam findings ___ Treatment(s) performed

___ Lab test results ___ Results of procedures ___ Other:_____

USES: The person requesting their information may use this information only for medical care and treatment.

DURATION: This authorization is effective immediately and shall remain in effect until revoked by me in writing. If not revoked in writing, this authorization will remain in place and will be updated every two years.

RESTRICTIONS: I understand that the requester for this information may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received ____ YES ____ NO Initial: _____

SIGNATURES:

_____ _____

Patient/Representative/Spouse**/Financially Responsible** Date

_____ _____

Witness Date

**A spouse or financially responsible party may only authorize release of medical information for use in processing an applications for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.