SNOWY RANGE KIDNEY CARE

*Form 4.3*

# Authorization for the Use and Disclosure of Protected Health Information

## PATIENT INFORMATION

**Patient Name:** _____

**Patient Address:** _____

**Patient SSN:** _____ **Date of Birth:** _____

**Maiden/Other Name:** _____ **Phone Number:** _____

## INSTRUCTIONS

*I authorize* _____ *to release my medical records for the service dates* _____ *to* _____

*For the following purpose:* ☐ *At My Request (patient only)* ☐ *Continuation of Care* ☐ *Insurance* ☐ *Legal* ☐ *Other*

**Release to: Snowy Range Kidney Care**

**Release to: Fax: 307-263-4023**

*Please release the following information in my medical record (check all that apply):*

| | | | |
|---|---|---|---|
| ☐ *Entire Medical Record* | ☐ *History and Physical* | ☐ *Med Sheets* | ☐ *Other:* _____ |
| ☐ *Medications* | ☐ *Laboratory Reports* | ☐ *Progress Notes* | _____ |
| ☐ *Radiology* | ☐ *Billing Records* | ☐ *Consultations* | _____ |

## SPECIAL INSTRUCTIONS

*Check one:* ☐ **Yes** ☐ **No** *I understand that the records used and disclosed pursuant to this authorization may include information relating to treatment or diagnosis of: Human Immunodeficiency Virus ("HIV") infection, Acquired Immunodeficiency Syndrome ("AIDS") or other sexually transmitted diseases; Hepatitis B&C; history of drug or alcohol abuse; or mental or behavioral health or psychiatric care; and/or other sensitive information. I authorize the release of the above listed information with the request.*

## ACKNOWLEDGEMENT

*I understand that this authorization is voluntary and may be revoked by me at any time in writing except to the extent that action has already been taken in reliance with this authorization.*

_____ _____

**Signature of Patient or Patient's Representative** **Date**
*(Personal & Legal Representative must include proof of status)*

☐ *Parent*
☐ *Personal Representative*
☐ *Legal Representative*

_____

**Printed Name of Patient or Patient Representative**

**FOR SRKC STAFF ONLY:**
☐ *Identity Confirmed by SRKC Staff*

*Printed Name of Employee:* _____

*Signature of Employee:* _____ *Date:* _____

*V. 2022*