

## Authorization to Disclose Protected Health Information The undersigned authorizes.

Nephrology & Hypertension Medical Associates 1115 Lexington Ave., Savannah, GA 31404 (P) (912) 354-4813 (F) (855) 427-3773 to release my health information as noted below:

Patient Information													
Patient Full Name:				Oth	er N	lame	es? _						_
Patient Address:			Da	Date of Birth:									
City:	_ State: _			Phone #:									
Release Information To													
Email address for record delivery	: Please ensu	ıre email	address is	legible!									
If email delivery is preferred, you must provide PDF file. If you do not retrieve your records with be a fee for collecting your records.If so, an invo	nin 30 days, they	will be dele	eted. You will	receive an email	0								
Name/Facility: Attention:													
Address:	ss: Phone:												
City:	State:	Zip	):	Fax #:									
Purpose of Request: Persona	al Trea	atment	Lega	lInsurar	nce _	Tra	ansfe	r	Othe	r:			
Information to be Released				If you fail to	specif	y, a 1	-year	abstr	act wi	II be j	orovide	ed.	
Please release a <b>1-year abstr</b> most recent notes, labs, proce	•	-	ncludes	1		se pi	ck O	NE d	elive	ry op	otion)		
Please release a <b>2-year abstr</b> notes, labs, procedures & test	•	-	office	[ ] Send by I [ ] Records			] Fax <sup>1</sup>	to Do	ctor	[]	Record	s on P	aper
Date Range: □ Progress Notes □ Radiology □ Operative Reports □ Injectio □ Other:	Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed O.C.G.A. 31-33-3												
Authorization to Release Prote	cted Healt	h Inform	nation										
I acknowledge and hereby con		•					•			hol,	drug a	abuse	<b>:</b> ,
psychiatric, HIV testing, HIV re						Pleas							
I understand that: I may refuse to enrollment or eligibility for benefication at any time in writing, but if I do, in otherwise revoked, this authorization of specify expiration this authorization provider, the released information understand that I may see and obtoin it. I can request a copy of this formation in the second secon	ts may not be the second to th	be condition to the condition of the information of	tioned on effect on a the follow s. If the rorotected formation	signing this a any actions ta ving date, evo equestor or r by Federal P	autho iken p ent, c eceiv rivacy	orizati orior f or cor or is y Reg	ion. I to rec ndition not a gulation	I may ceivir on: heal ons a	revoling the the the plant in the plant in the material representations and material representations.	revo n or ay be	is auth cation health disclo	norizat n. <b>Unl</b> <i>If I d</i> care osed. I	less Io
STOP Please confirm that				in its entire be unable to						or if	fprote	cted	
Signature*:							_						

<sup>\*</sup> For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.