Rocky Mountain Kidney Care

Form 4.3- RECEIVE

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: Rocky Mountain Kidney Care _____

Release to: Fax: 855-712-9183 or Mail: 1444 S Potomac Suite 215, Aurora CO 80012 _____

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.

_____ ☐*Parent* _____

Signature of Patient or Patient's Representative ☐*Personal Representative* **Date**

(Personal & Legal Representative must include proof of status) ☐*Legal Representative*

_____

Printed Name of Patient or Patient Representative

FOR RMKC STAFF ONLY:

☐ *Identity Confirmed by RMKC Staff*

Printed Name of Employee: _____

Signature of Employee: _____ *Date:* _____

V. 2018