Authorization for Release of Information

ATTN: Please Mail Records over 20 pages

Patient Name:_____ Date of Birth:_____

Last 4 of SS#:_____ Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Cell:_____

I hereby authorize_____

(Please put FORMER Doctor's office and/or medicalfacility name above)

TO RELEASE INFORMATION FROM MY MEDICAL RECORD AS INDICATED BELOW TO:

Cumberland Kidney Specialists

117 N Hickory Ave, Suite 200, Cookeiville TN 38501

(931) 646-0880 - PHONE

(866) 834-5618 - FAX

INFORMATION TO BE RELEASED:

( )History & Physical Exam
( )X-Ray Reports
( )Last 2 Years
( )Progress Notes
( )MRI, CT, Ultrasound
( )Lab Reports
( )Other
_____

_____ _____

Signature of Patient **Date**

Purpose of Disclosure:

( )Changing Physician
( )Continuing Care
( )Worker's Comp
( )Consultation/2nd Opinion
( )Insurance
( )Other _____
( ) Legal

1. **I understand that this authorization will expire on_____.**
2. **I understand that I may revoke this authorization at any time by notifying Cumberland Kidney Specialists office in writing. It will be effective on the date notified except to the extent that action has already been taken.**
3. **I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.**

_____ _____

Signature of Patient or Legal Guardian **Date**