NANI
Nephrology Associates of Northern Illinois and Indiana

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

PATIENT INFORMATION	
Name:	**Date of Birth:**
Address:	**Phone #:**
	MRN #:

DISCLOSURE OF HEALTH INFORMATION

I hereby authorize and request that my health information be OBTAINED FROM the following Facility/Entity/Individual:

From (Facility/Entity/Individual): _____ Phone #: _____

Address: _____ Fax #: _____

I hereby authorize and request that my health information be DISCLOSED TO the following Facility/Entity/Individual:

From (Facility/Entity/Individual): _____ Phone #: _____

Address: _____ Fax #: _____

PURPOSE OF DISCLOSURE

____ Legal ____ School ____ Medical Care ____ Transfer/Placement ____ Insurance

____ Personal Use ____ Other, specify:

METHOD OF DISCLOSURE

____ US Mail ____ Pick-Up ____ CD ____ Electronic Portal ____ Fax

____ Other (specify):

HEALTH INFORMATION TO BE DISCLOSED (CHECK ALL THAT APPLY)

____ Complete Medical Record

If not complete medical record, check all to be disclosed below.

____ Lab Result(s) ____ Radiology Report(s) ____ Operative/Procedure Report(s)

____ Pathology Result(s) ____ Progress Note(s) ____ EKG/Stress Test(s)

____ Consultation(s) ____ Discharge Summary(ies) ____ Prenatal Summary(ies)

____ Psych Evaluation/Testing ____ History & Physical(s) ____ Immunization(s); specify:

____ Other, specify:

DATES OF TREATMENT

Dates of treatment to be disclosed (specific date or date range): _____

Mental health record requests must have specific date entered.

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SPECIFIC CONSENT

If any of the highly confidential information listed below is contained in medical records requested, I authorize the use and/or disclosure of this information by checking the boxes below (if application to this authorization)

____ Not applicable to this authorization

____ Information about Mental/Behavioral Care & Treatment

____ Information about Substance Abuse Care & Treatment

____ Information about Psychological Testing

____ Information about Sexually Transmitted Disease(s)

____ Information about HIV/AIDS Testing or Treatment

____ Information about Genetic Testing

PATIENT ACKNOWLEDGEMENT AND UNDERSTANDING

This authorization shall be effective immediately and will expire on _____ or when the following event occurs: _____.

Mental Health Record requests must have a calendar date specified.

I understand that I can revoke this Authorization at any time, by doing so in writing to Adult Medicine Physicians. Such revocation is not retroactive, and does not affect any health information already used, disclosed, or relied upon by Adult Medicine Physicians or others.

I understand that the information disclosed pursuant to this authorization may include records, if present, relating to mental health, communicable disease, HIV/AIDS, or alcohol/drug abuse.

I understand that information disclosed pursuant to this authorization could be further disclosed by the recipient and may no longer be protected by federal or state law.

I understand that my information may be shared with a population health organization including, but not limited to, (Health Information Exchange and Clinically Integrated Networks) to facilitate the coordination of patient care.

I understand that my signing or refusing to sign this authorization IN NO WAY AFFECTS WHETHER OR NOT PATIENT CAN RECEIVE TREATMENT from Adult Medicine Physicians.

I have received a copy of this Authorization.

_____ _____

Patient Signature **Date**

If patient is minor or has legal representative or legal guardian:

_____

Signature of Parent, Legal Representative, or Legal Guardian

_____ _____

Name of Parent, Legal Representative, or Legal Guardian ***Relation to Patient***

_____ _____

Witness Signature **Date**