RENAL MEDICINE ASSOCIATES

Authorization to Release Medical Information (To RMA)

Patient Name: _____

Last 4 of SSN: _____ DOB: _____

Address: _____

The undersigned authorizes my healthcare providers to release to Renal Medicine Associates any and all medical records or reports, including hospital records, outpatient provider notes, radiology and laboratory reports, prescription information, and all information pertaining to my examination and treatment. This authorization includes the release of all information, with the exception of information concerning:

☐ Mental Health Records

☐ Communicable Diseases (Including HIV & AIDS)

☐ Alcohol/Drug Abuse Treatment

☐ Other (Please Specify): _____

☐ No Exceptions

I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

The above information is to be released for the purpose for continued medical care, treatment or consultation, billing and claims payment, or other purposes as I may direct. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____ _____

Patient Signature Date

_____ _____

Patient Guardian or Authorized Representative Date