**CONSULTANTS IN NEPHROLOGY AND HYPERTENSION PROFESSIONAL L.L.C.**

Yisfalem W. Alamdew, MD | Oscar G. Dominguez, MD | Balwinder S. Kang, MD | Behram K. Mohmand, MD

9397 Crown Crest Blvd Suite 401 Parker, CO 80138 | Phone 303-697-1636 Fax 303-805-9948

**Authorization to Disclose Medical Information to Consultants in Nephrology and Hypertension, PLLC**

**Patient Printed Name** **Date of Birth** **Previous Name**

**Disclose Requested Health Information From:**

**Name of Organization/Medical Provider** **Address** **City** **State** **Zip Code**

**Phone Number** **Fax Number**

**You May Disclose Requested Health Information To:**

**Consultants in Nephrology and Hypertension, PLLC**
**9397 Crown Crest Blvd Suite 401 Parker, CO 8013**
**Dr. Yisfalem Alamdew | Dr. Oscar Dominguez | Dr. Behram Mohmand | Dr. Balwinder Kang**

**My Authorization**

**You may use or disclose the following health care information (check all that apply):**
[ ] All my health information maintained by the above-named disclosing practice.
[ ] My health information relating to the following treatment or condition: _____
[ ] My health information for the date(s): _____
[ ] Other (please specify): _____

**I specifically authorize disclosure of the following conditions (check all that apply):**
[ ] Drug Abuse [ ] Alcohol Abuse [ ] HIV/AIDS [ ] Psychological or Psychiatric Conditions, Including Psychotherapy Notes

**I specifically decline disclosure of the following conditions (check all that apply):**
[ ] Drug Abuse [ ] Alcohol Abuse [ ] HIV/AIDS [ ] Psychological or Psychiatric Conditions, Including Psychotherapy Notes

**Reason(s) for this Authorization (check all that apply):**

[ ] At my Request
[ ] Other (please specify): _____

**This release will automatically expire in 1 year from the date signed below unless earlier revoked.**

**I understand that I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above- named practice based on this authorization. The disclosing provider generally may not condition treatment, payment, or enrollment or eligibility for benefits on completion of this release form. Once the office discloses health information, the person or organization that receives it may be able to re-disclose it. Privacy laws may no longer protect it.**

**Patient or Legally Authorized Individual Printed Name** **Relationship to Patient** **Signature** **Date**