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

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

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

Disclose Requested Health Information From:

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

You May Disclose Requested Health Information To:

[ ] Patient:______________________________
Printed Legal Name **Date of Birth** **Method of Release**

Electronic release of information (fax or email) is the most appropriate form of release of information. Consultants in Nephrology and Hypertension, LLC is not responsible for intercepted PHI as a result of printing or mailing PHI.

[ ] Other:

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

Phone Number **Fax Number**

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 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, 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**