RENALCARE CONSULTANTS, P.C.

Authorization to Release Medical Information

Patient _____ Birthdate _____

I consent to the release of Medical Information (records):

To(Physician, Clinic or Person)-

_____
_____
_____
_____
_____

From(Physician, Clinic or Person)-

_____
_____
_____
_____
_____

Information to be Released:

____ Standard Problem List, Medication Summary, Progress Notes, Health History, Immunization Records, Letters, X-ray & Laboratory Reports. **From Date**:_____**To Date**:_____
____ X-Ray reports only. Date(s) _____
____ Laboratory and Pathology reports only. Date(s) _____
____ Other tests or studies (list type of test/study and date performed) _____
____ Other (specify)_____

In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical record *: ***(initial if release is authorized)***

_____ Drug and alcohol abuse
_____ Information related to diagnosis/treatment of HIV

*Please note that a separate release is required for Behavioral Health Information

Purpose of Disclosure:

_____
_____

This authorization is **valid for six months** after the date of signature. The authorization may be revoked at any time (but not retroactive to a release of information made in good faith) by the undersigned if providing written notice of revocation.

_____ _____
Signature of Patient or Legally Authorized Representative Date

Revised 5/14/2002