Nephrology Associates of the Gulf Coast
8333 North Davis Hwy, Pensacola, FL 32514
Voice : 850-474-8121
Fax: 850-474-8096

Authorization for Release of Medical Records

Patient Name _____ Date of Birth _____

Release of Medical Information **FROM**:

Practice or Doctor's Name: _____

Phone: _____ Fax Number: _____

Practice Address: _____

Release of Medical Information **TO**: Please Fax Records ☐ Please Mail Records ☐

This information may be disclosed and used by the following individual or organization:

Release To: **Nephrology Associates of the Gulf Coast**

Address: **8333 N. Davis Hwy,**
Pensacola, FL 32514

Phone: 850-474-8121 Fax Number: 850-474-8096

The Release of Medical Information is for:

☐ Change of Physician ☐ Continuation of Care ☐ Referral ☐ Other _____

☐ All information regarding assessment, diagnosis, treatment, and laboratory results for the above listed patient.

☐ All information regarding assessment, diagnosis, treatment, laboratory results for the above listed patient for the following dates: From _____ (month/year) To _____ (month/year)

☐ Other information (specify): _____

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.**
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that authorizing the disclosure of this health information is voluntary. You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your healthcare provider in determining appropriate treatment.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Signature of Patient / Guardian or Authorized Representative Date

_____ _____
Printed Name of Authorized Representative Relationship to Patient