NEPHROLOGY ASSOCIATES

710 Main Street, Lewiston, Maine 04240

Patient____ Date of Birth______________________

I hereby authorize the release of information
TO: _____________________________________FROM: ___________________________________

____ ____

____ ____

The purpose of this release is to provide for my further care, to process my claim(s), or as stated here:

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I specifically consent to and authorize the release of information regarding my treatment or rehabilitation for substance abuse or regarding any psychiatric care if such treatment or care occurred. I specify this release to include:

___Final Diagnosis (es)
___Discharge Summary (ies)
___History (ies)
___Physical Exam(s)
___Consultation Report(s)
___Radiology/Imaging Report(s)
___Laboratory Result(s)
___Hepatitis B Test Result(s)
___HIV (AIDS) Test Result(s)
___Operative Report(s)
___Pathology report(s)
___Progress Notes
___Physician Order(s)
___Emergency Treatment Record(s)
___Psychiatric/Mental Behavioral Health
___Alcohol or Chemical Dependency
Other, Specify: ________________________
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This authorization pertains to information related to my treatment(s) on:
DATES From_______________________________ To____________________________________

I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization that receives the information.

THIS RELEASE MAY BE REVOKED AT ANY TIME IN WRITING SUBJEST TO THE RIGHT OS ANY PERSON WHO ACTED IN RELIANCE UPON THIS AUTHORIZATION PRIOR TO RECEIVING NOTICE OF REVOCATION. REVOCATION OD THIS AUTHORIZATION MAYALSO RESULT IN IMPROPER DIAGNOSIS OR TREATMENT, DENIAL OF COVERAGE OR A CLAIM FOR HEALTH BENEFITS OR OTHER ADVERSE CONSEQUENSES. A COPY OF THIS FORM IS AVAILABLE TO SIGNER UPON REQUEST.

____ _____________________________
Signature of Patient or Legally Authorized Representative Date

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Relationship