Nephrology Associates
OF TIDEWATER, LTD.

Authorization to Release Protected Health Information

○ **KEMPSVILLE**: 6160 Kempsville Circle, Suite 302A, Norfolk, VA 23502	Phone: 757-466-9288	Clinical Fax: 757-466-8123
○ **MEDICAL TOWER**: 400 Gresham Drive, Suite 907, Norfolk, VA 23507	Phone: 757-627-7301	Clinical Fax: 757-466-8154
○ **CHESAPEAKE**: 300 Medical Parkway, Suite 222, Chesapeake, VA 23320	Phone: 757-436-5544	Clinical Fax: 757-466-8773
○ **SUFFOLK/FRANKLIN**: 2790 Godwin Boulevard, Suite 255, Suffolk, VA 23434	Phone: 757-925-0637	Clinical Fax: 757-466-6794
○ **EASTERN SHORE**: P.O. Box 923, 9550 Hospital Avenue, Nassawadox, VA 23413	Phone: 757-442-9080	Clinical Fax: 757-466-8123
○ **VIRGINIA BEACH**: 1800 Camelot Drive, Suite 401, Virginia Beach, VA 23454	Phone: 757-496-3706	Clinical Fax: 757-466-8773

Name (First, Middle, Last)	**Birth Date (Month DD, YYYY)**	**SSN/Medical Record Number**

Instructions: If any section is incomplete, this form may be invalid.

Release Information From

☐ Nephrology Associates of Tidewater, Ltd. (office checked above)

☐ Other *(Specify healthcare provider/Facility/Company/Individual below, including phone/fax if known).*

_____

_____

_____

Release Information To

☐ Nephrology Associates of Tidewater, Ltd. (office checked above)

☐ Other *(Specify healthcare provider/Facility/Company/Individual below, including phone/fax if known).*

_____

_____

_____

Purpose of Release

☐ Treatment/Continued Care ☐ Personal ☐ Legal Purposes ☐ Disability Determination
☐ Payment of Insurance Claim ☐ Other:

Information to be Released (Required - check all that apply)

☐ Clinic Notes	☐ Hospital Discharge Summary	☐ Laboratory Reports	☐ Radiology Reports
☐ History and Physical	☐ EKG's	☐ Operative Reports	☐ Radiology Images
☐ Hospital Notes	☐ Immunization Records	☐ Pathology Reports	☐ Billing Information

☐ Other _____

Service Dates (Optional): FROM:_____ TO: _____

My Rights

I understand that authorizing the disclosure of this patient health information is voluntary. I understand that I do not need to sign this form in order to assure treatment or payment. I may be charged for copies in accordance with state law. I understand that this authorization may include release of the following sensitive medical information unless I have initialed below to exclude such information:

_____ mental health treatment _____ sexually transmitted diseases

_____ alcohol and/or drug abuse treatment _____ AIDS / HIV treatment

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

I understand that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information.

This authorization will expire in one year from the date of signing unless I indicate an earlier date or event here:

By signing, you agree that you understand and accept the terms on this form. If the patient is incapable of signing, a legally authorized substitute may sign and date the form with proper documentation.

Signature (Required)	Date Signed (Required) (Month DD, YYYY)
Printed Name of Person Signing (If Not Patient), and Indicate Legal Authority	