

Authorization to Release Protected Health Information

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| ○ KEMPSVILLE: 6160 Kempsville Circle, Suite 302A, Norfolk, VA 23502 | Phone: 757-466-9288 | Clinical Fax: 757-466-8123 |
| ○ FORT NORFOLK: 301 Riverview Ave., Suite 600, Norfolk, VA 23510 | 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: 757-455-6794 |
| ○ 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 |
| ○ PRINCESS ANNE: 1975 Glenn Mitchell Dr., Ste. 302A, Virginia Beach, VA 23456 | Phone: 757-689-0211 | Clinical Fax: 757-466-8123 |
| ○ MARYVIEW: 3640 High St., Suite 2G, Portsmouth, VA 23707 | Phone: 757-977-1110 | Clinical Fax: 757-466-8773 |
| ○ HARBOURVIEW: 5140 River Club Dr., Suite 102, Suffolk, VA 23435 | Phone: 757-977-1110 | Clinical Fax: 757-455-6794 |

Name (First, Middle, Last)	Birth Date (Month DD, YYYY)	SSN/Medical Record Number
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Instructions: If any section is incomplete, this form may be invalid.

Release Information From

Release Information To

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

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

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)

<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> History and Physical	<input type="checkbox"/> EKG's	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Radiology Images
<input type="checkbox"/> Hospital Notes	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Billing Information
<input type="checkbox"/> 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 redisclosure 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	