



**CLEVELAND  
KIDNEY  
DISEASE ASSOCIATES**

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Authorization to Disclose Personal Health Information

HIPPA Supplement Form

I, \_\_\_\_\_, hereby authorize CKD Associates to disclose my  
Patient Name  
 Health information to the following parties (family, next of kin):

Name	Address	Phone
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Name	Address	Phone
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Name	Address	Phone
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Patient Signature	/ /
	Date

Representative Signature	/ /
	Date