CLEVELAND
KIDNEY
DISEASE ASSOCIATES

ANDREW E LAZAR M D
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Authorization for Release of Protected Health Information (PHI)

I hearby request/authorize _____to use, disclose and/or release
(physician's office, hospital, lab, etc…)
my individually identifiable health information as described below. I understand that this authorization to release my individually identifiable health information is voluntary and that I may revoke the authorization in writing.

Patient Name (print): _____
Maiden/Previous Name (print): _____ Date Of Birth: _____
Social Security Number: _____ Approx. Date Last Seen: _____

Request for release of individually identifiable health information to the following facility/physician/person:

Name: **CKD Associates, Dr. Andrew E. Lazar, M.D.**
Address: **3619 Park East Drive, Ste 318 South**
Beachwood, OH 44122
Phone: **216-896-0639** **Fax:** **216-896-0663**

Description of information being disclosed:

□ **Progress Notes** □ **Operative Reports** □ **Discharge Summaries** □ **Pathology Reports**
□ **Renal Ultrasounds** □ **Renal Artery Duplex** □ **Renal Arteriograms** □ **MRI/MRA Reports**
□ **CT Scans** □ **Echocardiograms** □ **Chest X-ray** □ **Billing Records**
□ **All Laboratory Studies (i.e. Renal Panel, CBC, U/A, 24 Hour Urine)**
□ **Other:** _____

Purpose of Disclosure: At the request of the patient.

This authorization expires (choose only one):
[ ] 90 days from the date in which I, or my legal representative, signs this authorization
[ ] upon the happening of the following event: _____

Patient/Representative Signature: _____
Patient/Representative (print): _____
Legal Authority of Representative to sign on behalf of the patient : _____
Representative verified by: _____ Date: _____