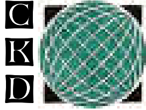

CLEVELAND
KIDNEY
DISEASE ASSOCIATES

ANDREW E LAZAR M D
3619 PARK EAST DRIVE
STE 318 SOUTH
BEACHWOOD OH 44122
216 896 0639 FAX
216 896 0663
WWW CLEVELANDKIDNEY CO
M

Authorization for Release of Protected Health Information (PHI)

I hereby request/authorize Cleveland Kidney Disease Associates to use, disclose and/or release 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 addressed to CKD Associates at 3619 Park East Drive, Suite 318 South, Beachwood, OH 44122. This authorization may not be revoked where CKD Associates has reasonably acted in reliance on this authorization. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

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:____
Address:____
____
Phone:______________________________ **Fax:**_________________________

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: _________________________________

Treatment or payment may not be conditioned on the execution of this Agreement, except for research-related treatment and treatment solely for the purpose of disclosure to a third party based on this release.

Patient/Representative Signature: _______________________________________
Patient/Representative (print): ____
Legal Authority of Representative to sign on behalf of the patient : _________________
Representative verified by: _________________________ Date: ____________________

Additional information can be found in the CKD Associates Privacy Practices. You will be given a copy of this Authorization with a copy filed in your medical record.