NORTHEAST LOUISIANA KIDNEY SPECIALISTS, LLC
Richard O'Donovan, MD *Michael W. Archie, MD* *Michael R. Hand, MD*
Frederick B. Lee, MD *Nkeekam O. Anumele, MD* *Kim Sherrill, BCFNP*

Authorization for Release of Health Information

I authorize the use and/or disclosure of my protected health information (PHI) as described herein. I understand that, if the person(s) or organization(s) that I authorize to receive and/or use my PHI are not subject to federal and state health privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____

I authorize the following person(s) and/or organization(s) to:

____ **disclose** my protected health information (as specified below) **to** **Northeast Louisiana Kidney Specialists**.
____ **receive** my protected health information (as specified below) **from** **Northeast Louisiana Kidney Specialists**.

Provider Name: _____

Address: _____

I authorize Northeast Louisiana Kidney Specialists to:

____ **receive** my protected health information **as disclosed by** the person(s) and/or organization(s) listed above.
____ **disclose** my protected health information **to** the person(s) and/or organization(s) listed above.

Specific descriptions of the protected health information that I authorize for disclosure:

___ Medical History (including, but not limited to: progress notes, x-ray reports, outpatient test results, lab results)
if any of the below apply, please check also:

___ Alcohol and/or Drug Dependency Records

___ HIV (AIDS) Antibody Test Results and Diagnosis/Treatment Records

___ Other: _____

I understand that this authorization is voluntary and that I may revoke it in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

This authorization expires on _____.
(date)

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction and that a photocopy of this form is as valid as the original to allow release of my records.

Signature: _____ Date: _____
Relationship required if not signed by patient

Witnessed by: _____ Date: _____

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