2001 Auburn Hills Pkwy,
Ste 801, McKinney, TX 75071

Authorization for Disclosure of Health Information

Patient name: ____

Date of birth: ______________________________ **Phone:** ________________

Address: ____

City: ____________________ **State:** ______________ **Zip:** ______________

I request and authorize to release the medical records of the above-named individual to:

Texas Kidney Partners
2001 Auburn Hills Parkway, Ste 801
McKinney, TX 75071

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

______ Complete health records
______ Medical exam
______ Immunization record
______ Other (please specify): ____
______ Lab results/X-ray reports
______ Consultation reports

Your initials are required to release the following information:

_____ Mental Health Records ______ Genetic Information (including Genetic Test Results)

____ Drug, Alcohol, or Substance Abuse Records ______ HIV/AIDS and Sexually transmited Disease Test Results/Treatment.

Covered entities as defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individuals protected health information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ___________________________________. If I fail to specify an expiration date, event or condition, this authorization will expire in 365 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to receive continued treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

____ ______________________
Signature of participant or representative **Date**

______________________________________ ______________________________________
Name of patient or representative **Description of personal representative's authority**

Privacy Officer Comments:

☐ Request accepted

☐ Request rejected

Reason: ____
____
____

☐ Patient contacted