METROLINA
NEPHROLOGY ASSOCIATES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **DOB:** _____ **MRN:** _____

- I authorize the use or disclosure of the above-named individual's MNA health information as described below.
- The type and amount of information requested or to be disclosed is as follows (check all being requested):

☐ Problem list	☐ Medication List	☐ Allergy List	☐ Immunization Record
☐ History and Phys.	☐ Consultation Reports	☐ Hospital Recs	☐ Laboratory Results
☐ Radiology Reports	☐ Office Notes	☐ Entire Record	☐ Other _____

- Dates of Records Requested: **From Date:** _____ **To Date:** _____

- The purpose of the requested use or disclosure is: ☐Patient Use ☐Coordination of Care ☐Legal Request

  ☐Other:_____

Requesting From: _____	Send To: _____
Name/Practice: _____	Name/Practice: _____
Address: _____	Address: _____
Fax: _____	Fax: _____
Phone:_____	Phone: _____

- Please provide/send my records in the following manner: _____

- I understand that the information in my health record may include information relating to ***Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV)***. It may also include information about behavioral or mental health services, and lab results or treatment for alcohol and drug use. I understand that I have the 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 MNA Privacy Officer or his/her designated person. I understand the revocation will not apply to information that has already been released in response to this authorization. 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 six months. I understand that authorizing the disclosure of this health information is voluntary. 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. If I have questions about disclosure of my health information, I can contact the MNA Privacy Officer at 704-332-0396.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

If Legal Representative, Relationship to Patient