KSOSN | KIDNEY SPECIALISTS OF SOUTHERN NEVADA

AUTHORIZATION TO RELEASE/ DISCLOSE HEALTH INFORMATION

DATE	HEALTH RECORD NUMBER	PATIENT'S DOB

PATIENT'S NAME (Last) (First) (M.I)

I _____ , authorize the use and disclosure of the above name individual's health information described below. The following individuals or organizations have authorization to make disclosure of my health information records.

ORGANIZATION'S NAME	**KIDNEY SPECIALISTS OF SOUTHERN NEVADA**				
ADDRESS	**500 S. RANCHO DR., STE. 12**				
CITY	**LAS VEGAS**	STATE	**NV**	ZIP	**89106**

RELEASE INFORMATION TO

ORGANIZATION'S NAME	
ADDRESS	
PHONE NUMBER	FAX NUMBER

DATE RANGE OF RECORDS TO BE RELEASED: From: _____ , 20 _____ to: _____ , 20 _____

I WOULD LIKE A COPY OF MY RECORDS ON ☐ Paper ☐ CD ☐ MyChart Patient Portal ☐ Secure email

☐ Entire Health Records	☐ Transplant Information	☐ X-Ray Results	☐ Financial Information
☐ History & Physical	☐ Biopsy Results	☐ Lab Results	☐ Other: _____.
☐ Prescription List	☐ Hospital Records	☐ Progress Notes	

This authorization to release health information expires on: _____, 20 _____ . If no date is provided the Authorization will expire one year from the signature date. I understand that the information in my health records 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 services, and the treatment for alcohol and drug abuse. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information privacy officer. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when it provides my insurer with the right to consent a claim under my insurance policy unless otherwise revoked. **This authorization will expire on the following date or condition: _____, 20 _____. If I fail to specify an expiration date, event or condition this authorization will expire one year from the signature date below.** If I have any questions regarding this disclosure of my health information, I can contact the privacy officer at 702-877-1887.

_____ _____

Patient Signature or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Date