Renal and Transplant Associates Of New England, PC

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RELEASE OF MEDICAL INFORMATION

PLEASE PRINT

Patient Name: ____ D.O.B: __________________________________

Address: ____

Contact phones: ____

I hereby authorize Renal and Transplant Associates of New England PC to disclose my protected health info to:

Doctor: _________________________ Facility Name: ____
Address: ____
Phone: ____ Fax: ____

I understand that Renal and Transplant Associates of New England is authorized by me to use and disclose my protected health information for a purpose other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Renal and Transplant Associates of New England, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed above. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

____ **I authorize the release of the info for the period From**: __________**Through**: _________or ***for all records***.

Please release: (check the ones that apply to you)	Please **check and initial** if the following apply to your health Information.
___ Office Notes ___ Laboratory Studies ___ Other: _________________________________ **Note: Per HIPAA we do not disclose any third-party records**	___ Sexually Transmitted Disease, HIV/AIDS ______ ___ Substance abuse _________

The purpose of the release of this information is for:

___ Transfer of care (We do charge a Fee for copies)
___ Continuity of care (We do charge a Fee for copies)
___ Personal use (We do charge a Fee for copies)
___ Other: _______________________________

Note: Please advise: In accordance with **the Mass Law Chapter 111 Section 70** Renal and Transplant Associates of New England has the right to charge a reasonable fee for copies of Medical records.

I have the right to revoke this authorization at any time. ALL revocations must be sent to **Renal and Transplant Associates of New England** to the attention of the Privacy Officer and are not effective until received by the Privacy Officer. This revocation will not apply to information which has already been released. This authorization will expire in (90 days) from the date of signature, except when Federal and/or State regulation specify otherwise. I fully understand and accept the terms of this authorization.

____ ______________________________________

Patient's Signature (or legal representative) Date

____

Relationship to patient: ***(if other than the patient is signing; a legal power of attorney must be presented)***