COLUMBIA NEPHROLOGY ASSOCIATES, P.A.

Patient Authorization for Release of (PHI) protected health information to another person.

(Spouse, Friend, Family)

By signing, I authorize Columbia Nephrology to release verbal information or copies of protected health information (PHI) about me to: (list person below)

____
____
____

This authorization permits Columbia Nephrology to release the following individually identifiable health information about me (medical notes, labs, or any accounting information to the person listed above).

The information will be used or disclosed for the following purpose: for continued medical care and at the request of the patient.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

My Patient Rights are:

I do not have to sign this authorization in order to receive treatment from Columbia Nephrology. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Law. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Columbia Nephrology 121 Park Central Drive, Suite 200, Columbia, SC 29203

Signed by: ______________________________ ______________________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **RELATIONSHIP TO PATIENT**

____

PRINT PATIENT NAME AND DATE