AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR

NEPHROLOGY ASSOCIATES OF KENTUCKIANA, PSC

6400 DUTCMANS PARKWAY • SUITE 250
LOUISVILLE, KY 40205

A. Authorization, I hereby authorize Nephrology Associates of Kentuckiana, PSC, including employees and agents of the provider (collectively "Provider"), to use and release my medical files, or copies of the files, and the information in the files ("Medical Records") as described in this Authorization for Release of Medical Information, in connection with diagnosing and treating me; obtaining payment for services provided to me; and carrying out Provider's health care office operations. I further authorize Provider to provide my Medical Records to:

1. other providers involved in or consulted about my care;
2. third party payors who cover or may cover health services provided to me;
3. Provider's billing agent or company;
4. The Kentucky Department of Insurance, third party payore, health plans or other appropriate government agencies in connection with reporting, complaints or other enforcement regarding my rights as a Patient to receive care or payment and Provider's right to provide care or to receive payment from third party payors;
5. The National Commission on Quality Assurance or other accreditation organizations that may be authorized to review Provider's records in connection with quality assurance and other programs of third party payors; and/or
6. Other federal, state or local government agencies with authority to audit Provider's records, including, for example, the Medicare and Medicaid authorities and their agents.

B. Specific Recipient Requested to Receive Medical Records. In addition to the above, I specifically request and authorize release of my Medical Records or Medical Information to _____

_____

C. I _____ give my permission for Nephrology Associates of Kentuckiana PSC, to leave a message on my answering machine at telephone number _____.
I _____ give my permission for Nephrology Associates of Kentuckiana PSC, to call me at work at telephone number _____.

D. Medical Records. I acknowledge and agree that the term "Medical Records" may include notes by physicians and other professional personnel, test results and reports, correspondence, x-rays and other diagnostic imaging films, results and reports, as well as claims, billing and payment information.

E. Specific Records Expressly Included. I expressly authorize release of the following information, if it is part of my Medical Records (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

- ❑ Psychiatric, Psychologist or Psychotherapy or Mental Health
- ❑ Chemical Dependency / Substance Abuse ❑ Drugs ❑ Alcohol
- ❑ Sexually Transmitted Diseases

F. I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as rights I have regarding my protected health information.

I understand that this Authorization shall remain in effect unless it is revoked by me. I further understand that I may revoke this Authorization at any time by notifying Provider in writing. Except that any revocation by me shall not have any effect on any action taken by Provider in reliance on this Authorization before Provider received my revocation.

_____
Printed Name of Patient or Patient's Representative

_____
Patient's Social Security Number

_____
Relationship of Representative to Patient

_____
Patient's Date of Birth

_____
Signature of Patient or Patient's Representative

_____
Date