Authorization to Release Health Information

2110 Harrisburg Pike, Suite 310, Lancaster, PA 17604 Ph (717)544-3232 Fx (717)544-3237

Hypertension and Kidney Specialists

Name: _____

Address: _____

Phone: _____ Date of Birth_____

I authorize Hypertension and Kidney Specialist to (choose all that apply)

- ☐ Release my Medical Information to
- ☐ Obtain Medical Information from

Name: _____

Address: _____City: _____State: _____

Zip code: _____ Phone: _____ Fax: _____

Specific information such as (choose all that apply)

- ☐ Entire Record
- ☐ Labs
- ☐ X-ray/Radiology report
- ☐ Billing records
- ☐ Office Notes
- ☐ Hospital Records

I authorize Hypertension and Kidney Specialist to release any information regarding:

(Initial and sign below if you authorize Hypertension and Kidney Specialist to release this information to the above provider)

_____ Substance Use _____ Psychiatric/Mental Health

_____ HIV Testing

Signature: _____ Date: _____

I understand that once my Health Information is released it may not be protected by the federal privacy law. This authorization will expire in six months from the date signed. Requested records will be available within 5-7 days from date of signed of consent.