



Authorization to Share Medical Information

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with the federal government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA) of 1966, in order for your physician or the staff at Jacksonville Nephrology PA to give copies of and/or discuss your condition/exam/procedures/results with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so.

I authorize Jacksonville Nephrology PA to release any and all information (including verbal information, copies of results, appointment information) concerning my medical care to the following individual(s):

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

I DO NOT authorize Jacksonville Nephrology PA to release any information concerning my care to any individual.

Patient DOB: _____

Printed Patient Name: _____

Signature of Patient or

Parent/Guardian: _____ Date: _____