South Florida Nephrology Group, PA
722 Riverside Drive, Coral Springs Florida 33071
Phone: (954) 345-4333 Fax: (954) 345-4334

I hereby authorize: ***To disclose to:***
South Florida Nephroplogy Group, PA

_____
Physician's Name

_____
Address

_____
City State Zip

_____
Phone Fax

Records and information pertaining to:

_____ _____
Patient's Full Name Date of Birth

_____
Address City State Zip Phone Number

Duration: This authorization is effective immediately and will remain in effect for one year from the date of signature, unless a different date is specified here: _____.

The recipient of this protected health information will not re-disclose the information, except with a written authorization or as specifically required or permitted by law.

Upon request, the patient will receive a copy of this completed authorization form.

Revocation: This authorization is subject to written revocation by the patient at any time.

Specify Records: Sign to specify which type of information is to be disclosed.

Medical Information _____ _____
Signature Date

Psychiatric Information _____ _____
Signature Date

Drug/Alcohol Information _____ _____
Signature Date

Results of HIV Test _____ _____
Signature Date

The recipient may use the health information authorized on this form for the following purposes: ☐Continuity of Care ☐Insurance Change ☐Referral ☐Other _____

Notes:

_____

_____

A copy of this authorization is as valid as the original.

_____ _____
Signature Date

If signed by someone other than patient, indicate relationship: _____