Authorization for the Use / Disclosure of Protected Health Information (PHI)

I acknowledge that the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person(s) or organization authorized to receive the information is not a health plan or health care provider, the release may no longer be protected by federal privacy regulations.

I authorize Mountain Kidney & Hypertension Associates, P.A. to disclose information in my health record.

_____	_____	____/____/____
Signature of Patient or Representative	Printed name of Patient or Representative	Date

Relationship of Representative to Patient _____

I authorize Mountain Kidney & Hypertension Associates, P.A. to disclose information in my health record to the following individual(s) / organization(s):

_____	_____	____/____/____
Name / Relationship	Address	Phone number
_____	_____	____/____/____
Name / Relationship	Address	Phone number
_____	_____	____/____/____
Name / Relationship	Address	Phone number

The patient or representative MUST read and initial the following statements:

1) I understand that I may revoke this authorization at any time by notifying Mountain Kidney & Hypertension Associates, P.A. in writing, and understand that it won't have any effect on any actions Mountain Kidney &Hypertension Associates, P.A. took before receiving this revocation.
   Initials: _____

2 I understand that Mountain Kidney & Hypertension Associates, P.A. cannot make me sign this authorization as a condition to receive treatment *EXCEPT*when Mountain Kidney & Hypertension Associates, P.A. provides me with research-related treatment.
   Initials: _____