AUTHORIZATION TO OBTAIN
PROTECTED HEALTH INFORMATION

I authorize Kidney Care and Transplant Services of New England, P.C. to obtain my protected health information as directed below.

Any information not to be released is specified below. I acknowledge that I have signed this authorization voluntarily. I understand that Kidney Care and Transplant Services of New England, P.C will provide me with a signed copy of this authorization.

PLEASE PRINT ALL INFORMATION

• **STEP 1 INFORMATION ABOUT PATIENT**		
Name	Date of Birth	Phone
Street	City State Zip	

• **STEP 2 COMPLETE THIS SECTION FOR REQUESTS TO ANOTHER PROVIDER FOR RECORDS**
I hereby authorize _____ to release copies of my records to: Kidney Care and Transplant Services of New England, P.C. 2150 Main Street Springfield, MA 01104 Fax: 413-417-2978

• **STEP 3 TYPES OF RECORDS TO BE RELEASED**	**REASON FOR REQUEST**
____ Copies of medical records, including all office visits and diagnostic test reports, hospital notes, current medication lists, consultant reports and immunization records.	_____ _____

I understand that I may revoke this consent at any time, except where information has already been released.
This authorization is valid for a sixty (60) day period from the date it is signed, unless revoked.

Signature of patient/empowered representative: Relationship

Signature of Witness **Date**

* This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. I give consent to release this information.

Signature of patient/empowered representative: Relationship

Signature of Witness **Date**

* This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. I give consent to release this information.

Signature of patient/empowered representative: Relationship

Signature of Witness **Date**

Prohibition of Disclosure: This information is being disclosed from records when confidentiality is protected by Federal Regulation 42 CFR, Part 2, and cannot be reproduced without written authorization by the patient or his/her empowered representative.