Delmarva Kidney & Hypertension Specialists, LLC
910 Eastern Shore Drive
Salisbury, MD 21804
Phone: 443-978-7319 Fax: 443-736-2226

Request and Authorization for Release of Protected Health Information

NAME ____
Last **First** **Initial**
ADDRESS ____
Street **City** **State**
BIRTHDATE _____________________ **AGE** ________ **PHONE #** __________________________

I hereby authorize and consent to disclosure of health records as stated below. Delmarva Kidney & Hypertension Specialists, LLC can **release and/or request** the following portions of medical records of the named patient, via fax machine, verbally or photocopy. A facsimile signature will be considered an original for this purpose.

Check one below:

_____ Entire medical record, **including** mental health, alcohol or drug abuse and/or HIV/AIDS information.

_____ Entire medical record, **with the exception of** information regarding mental health records, including alcohol or drug abuse and HIV/AIDS related treatment.

_____ The following specific portions of the medical record.

Specified Medical Record

INDIVIDUAL/INSTITUTION

RELEASING INFORMATION	RECEIVING INFORMATION
Name ___________________________	Name ________________________________
Address _________________________	Address_______________________________
_______________________________	____________________________________
_______________________________	____________________________________
Phone #:_________________________	Phone #: ______________________________

PURPOSE OR NEED FOR THE INFORMATION___________________________________

It is understood that this request and authorization may be revoked by me (us) at any time in writing except to the extent that action has been taken in reliance thereon. It is also understood that this consent will expire 60 days from the date signed or upon the subsequently specified date, event, or condition:
____

I (we) further agree that the Practice may charge me or any designated recipients the actual cost incurred in preparing the copy of the requested Medical Records.

SIGNATURE __________________________ DATE_______________________
ADDRESS ____________________________ PHONE _____________________

INDICATE PERSON SIGNING BY CHECKING APPROPRIATELY BELOW:

_____ Patient _____ Parent/Guardian of minor patient_____ Guardian of incompetent patient
Deceased patient's: _____ Personal Representative; if none, _____Spouse; if none _____ Any Child

It is understood that the foregoing is confidential information and will be considered as such. Furthermore, Delmarva Kidney & Hypertension Specialists, LLC is hereby released from any legal liability that might arise from release of such information.

___________________________________	____
Patient Name (Print)	Social Security #
___________________________________	____
Patient Signature/Authorized Guardian	Date
___________________________________	____
Witness	Date