AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient. This authorization may be revoked by the patient at any time.

I hereby authorize: Naples Nephrology 878 109th Ave N #2, Naples, FL 34108

To disclose to: Nephrology Wellness

The health records of:

Name:_____
Last First MI Previous Name

_____
Birth Date Social Security # Telephone #

Address:_____
Street City State Zip

Type of information disclosed: Any and all records maintained by Naples Nephrology in the provision of healthcare services to me, including verbal, electronic and paper records.

For the purpose of: Providing wellness and other related services to me as well as notifying me about other service offerings I may benefit from

I understand that this will include information relating to (check and initial if applicable):
_____ ☐ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV)
_____ ☐ Behavioral health service/psychiatric care/mental health records
_____ ☐ Treatment for alcohol and/or drug abuse

Affirmation of Release
I give Naples Nephrology permission to release only the information I have selected on this form to the individual(s) or entities I have named and only for the purposes I have stated. I understand that this release is valid until the expiration date listed below and I may refuse to sign this authorization or revoke this authorization at any time. **Any revocation or refusal to sign this authorization will not affect my ability to obtain health care services from Naples Nephrology.** The revocation will take effect on the day it is received in writing. Copies of the records may be obtained by me with reasonable notice and payment of copying costs. I understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations. I further understand that the Recipient WITHOUT FURTHER AUTHORIZATION, may redisclose said information to parties and their legal counsel, insurers, reinsurers, experts, potential experts, anyone against whom a claim has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any said persons.

_____
Signature of Patient Date Signed
Expiration Date: Upon death; unless patient notifies provider sooner of revocation of this authorization