



**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_  
MRN: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email: \_\_\_\_\_

**DaVita Medical Group and its entities will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.**

This authorizes the following DaVita Medical Group clinic(s)/affiliate(s):  
\_\_\_\_\_  
\_\_\_\_\_

to disclose information as specified below for the following purpose(s):

- Personal  Legal  Insurance purposes
- Continued medical care
- Other \_\_\_\_\_

**DaVita Medical Group may disclose this information to:**

**Check if same as above (disclosure to patient)**

**Recipient**

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_  
**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Phone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_  
**Email:** \_\_\_\_\_

**Copies of records or medical record information within the following dates:** \_\_\_\_\_ to \_\_\_\_\_

- Medical office/Clinical records  Hospital records  All records for specified physician or facility/clinic
- Records limited to a specific provider \_\_\_\_\_ or Department: \_\_\_\_\_
- X-ray films  X-ray digital images  Laboratory results  Billing/Claims information

**Note: Hospital and medical office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.**

**The actual treatment records from restricted or sensitive health information are specifically protected, and will not be disclosed unless you sign below.**

- Mental/behavioral Health records** → Signature: \_\_\_\_\_
- Alcohol/drug dependency treatment records** → Signature: \_\_\_\_\_
- HIV testing results/AIDS treatment** → Signature: \_\_\_\_\_
- Sexually transmitted disease (STD)** → Signature: \_\_\_\_\_
- Genetic testing/test results** → Signature: \_\_\_\_\_

**Media type:**  Electronic  Paper **Delivery preference:**  Email/secure portal/encrypted  US Mail  Pickup

**Duration:** This authorization shall remain in effect for one year from the date of signature unless a different date is specified here \_\_\_\_/\_\_\_\_/\_\_\_\_ (date).

**Revocation:** Patient or Personal Representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

**Re-disclosure:** Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before disclosing this information.

**Fee disclaimer:** Federal and state laws permit DaVita Medical Group to charge a reasonable fee for copying/releasing records. State regulated fees for labor and supplies may apply. You will be notified in advance regarding any fees and payment as required.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
**If not the patient, print your name and relationship. Verification of Right to Request, if not patient, e.g. legal documentation, required.**

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**Office use only:** Date received: \_\_\_\_/\_\_\_\_/\_\_\_\_ Received by (Print name/Initial): \_\_\_\_\_/\_\_\_\_\_