RenalCare Associates, S.C.

PATIENT'S NAME: _____

Consent for release of information:

Below please list those with whom we can discuss your medical care. Please list their name and relationship to you (i.e. spouse, child, parent, all physicians).

_____ Name & Relationship	_____ Name & Relationship
_____ Name & Relationship	_____ Name & Relationship
_____ Name & Relationship	_____ Name & Relationship

Authorization for release of information:

___My ___My child's medical records and information pertaining to my/his/her medical history, mental or physical condition, services rendered, or treatment.

___**The medical records and information belonging to this patient for whom I have authorization/power or attorney/guardianship** (copy of authorization to be attached) pertaining to his/her medical history, mental or physical condition, services rendered, or treatment.

This authorization is limited to the following medical records and type of information:

__Demographics	__Medical History	__Services rendered
__Insurance information	__Physical exam findings	__Treatment(s)performed
__Lab test results	__Results of procedures	__Other:_____

USES: The person requesting this information may use this information only for medical care and treatment

DURATION: This authorization is effective immediately and shall remain in effect until revoked by me in writing. If not revoked in writing, this authorization will expire two years from the date this authorization was signed.

RESTRICTIONS: I understand that the requester of this information may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: __Yes __No Initial:_____

SIGNATURES:

_____ _____
PATIENT/REPRESENTATIVE/SPOUSE**/FINANCIALLY RESPONSIBLE** DATE

_____ _____
WITNESS DATE

**A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan, or an employee benefit plan.