Dialysis Clinic, Inc.
A Not-For-Profit Corporation

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize_____ to disclose to the following person or class of persons:_____
(Name of DCI Clinic)
_____ the following information from my health record:

Check (√) all that apply:

_____ Flowsheets	_____ Long Term Care Plans	_____ Medication Summaries
_____ Short Term Care Plans	_____ Progress Notes	_____ Consents
_____ Physician Orders	_____ Laboratory Results	_____ Demographic Information
_____ Billing	_____ Other (Please List)_____	

covering the period of health care from:_____ to: _____
(Date) (Date)

For the following purposes:_____
_____

If the above requested information includes treatment for mental illnesses and psychiatric conditions, drug or alcohol abuse, drug-related conditions, alcoholism, HIV testing results, and the treatment or diagnoses of AIDS or an AIDS-related condition, I agree for this information to also be released.

This authorization expires on: _____
(Date or Event, e.g., transfer)

I understand that:

- I have the right to refuse to sign this authorization.
- I have the right to revoke this Authorization at any time by sending a written request to this effect to the entity or person I have authorized to disclose the information.
- Any revocation that I make of my Authorization for disclosure will not be effective for any disclosure of information made before The person or entity releasing the information is given notice of the revocation.
- The information used for disclosure under this authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that require health care providers to protect individually identifiable health information; and
- The provider will not condition your right to treatment or payment on your granting this requested authorization unless the health care you will receive is for the purpose of disclosure to a third party and this authorization relates to its disclosure to that third party.

_____ Patient Name (Printed)	_____ Witness Name (Printed)
_____ Guardian Name, if applicable (Printed)	_____ Witness Title
_____ Patient/Guardian Signature	_____ Witness Signature
_____ Authority of Personal Representative if signing for the Individual (e.g., Power of Attorney) **Attach documents evidencing type of authority.**	_____ Witness Signature
_____ Date	_____ Date

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Revised: 2/12/03, 2/19/03, 6/24/03, 7/09/04, 3/8/07, 5/2/25