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AUTHORIZATION AND RELEASE FOR MEDICAL RECORDS

I hereby authorize the designated records custodian for «Custom1» (the "Covered Entity"), to release, upon presentation of this authorization, to **Charleston Nephrology Associates, LLC** and any of their agents or designees, copies of any and all recorded and oral information concerning _____ including by way of example, but not limited to the following:

> all medical records, physicians' records, surgeons' records, x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films, pathology materials, slides, tissues, laboratory reports, discharge summaries, progress notes, consultations, prescriptions, pharmacy records, or treatment, physicals and histories, nurses' notes, patient intake forms, correspondence, psychiatric records, psychological records, social worker's records, insurance records, consent for treatment, statements of account, bills, invoices, or any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, diagnosis or other information pertaining to and concerning the physical or mental condition of «PLFI» including the following, if indicated.

This release authorizes the Covered Entity to release the entire, unredacted records, pursuant to 45 CFR § 164.508 (HIPAA Authorization Requirements for Release of Protected Health Information), to the extent necessary for the purpose in question.

I understand that the information disclosed under this authorization and release of medical records may be re-disclosed by the person(s) specified above and may no longer be subject to the same protection the information is given by the Covered Entity.

I understand that these medical records are confidential. I also understand that by signing this authorization I am specifically authorizing the release of pharmacy and prescription information and records that may be protected by state law or regulations.

I understand that I may revoke this authorization in writing at any time as explained by the Covered Entity in its Notice of Privacy Practices, except to the extent that action has already been taken in reliance upon this authorization and release of medical records. I also understand that I have the right to refuse to sign this authorization and release of medical records. I also understand that the Covered Entity may not condition the provision of treatment, payment or enrollment in the health plan or eligibility for benefits based on my refusal to sign this authorization except when the release of information under this authorization is required for a health plan during initial enrollment for underwriting purposes, my participation in a research study or when treatment is provided solely for the purpose of disclosing it to a third party such as a work-related physical done at my employer's request.

You are hereby released from any and all liability in connection with the disclosure of records, documents, writings and physical evidence to the above designated person(s). This authorization also includes the authority to copy and inspect any and all such information and to discuss the information with the above designated person(s). A copy of this authorization may be used in place of and with the same force and effect as the original.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Name of Personal Representative (If Applicable)	Signature of Personal of Representative	Date

Patients DOB: _____

Witness:

_____	_____	_____
Signature	Printed Name	Date