ALTITUDE KIDNEY HEALTH, PLLC

PATIENT AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

1) **Purpose and Benefits.** The purpose of this form is to give consent to your provider at Altitude Kidney Health to obtain your pertinent protected health information ("PHI"), or to disclose your protected health information to authorized recipients, for the express purpose of facilitating your direct patient care.

Patient name	Date of Birth	Last 4 of social security number
Street Address	City, State, Zip code	Telephone number
I authorize ______________________ facility with address ______________________, city/state/zip code ______________________, phone ______________, fax ______________ to disclose protected health information to Altitude Kidney Health, PLLC with mailing address 1260 S Parker Rd, #202, Denver, CO 80231, for the purpose of continuing medical care.		
Treatment dates: ____________ Disclose by: ☐ Fax ☐ Mail	Documents including: ☐ Last provider notes ☐ H&P and discharge summary ☐ Operative reports	☐ Labs ☐ Medications ☐ Radiology reports ☐ Other: ______________

2) **Authorization**: I hereby make this request voluntarily. I certify that the above information is accurate to the best of my knowledge. A copy of this authorization is valid as the original..
3) **Refusal/revocation**. I am aware that I may refuse this disclosure and that my refusal will not affect my ability to obtain treatment or benefits. I am aware that I may revoke this authorization at any time in writing by submitting my request to the management or medical records department.
4) **Nondisclosure of information publicly**. I authorize this disclosure with the explicit knowledge that my PHI will be kept confidential in compliance with HIPAA standards *unless if I check here:* ☐*. In checking this box, I authorize the public dissemination of information for educational or promotional purposes, with identifying information redacted where possible..*
5) **Validity.** This authorization will expire upon satisfactory disclosure of information, or in 90 days from the date of signing unless if I check either of the following boxes: ☐ 12 months or ☐ ___________(write specific date).
6) **Acknowledgement.** I am aware that information involving my health history including medical conditions, treatments, communicable disease, psychological or psychiatric conditions, substance usage, etc may be included.

Signature:____ **Date**:________
Patient/parent/legal guardian (or person authorized to give consent)

If signed by person other than patient, provide:

Name	Relationship to patient	ID/driver's license number:
Witness name:	Witness signature	Date