Authorization for Release of Information

I, _____, hereby authorize _____,

to disclose the following protected health information to Renal Associates of Alabama, LLC.

_____

_____

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Renal Associates of Alabama, LLC in the following manner:

_____

_____

This authorization shall be in force and effect until _____ at which time to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Privacy Officer at Renal Associates, LLC, 6228 Bradley Park Drive, Suite A, Columbus, GA 31904. I understand that a revocation is not effective to the extent that Renal Associates, LLC has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Renal Associates, LLC will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____ _____

Signature of Patient or Representative Printed Name of Patient or Representative

_____ _____

Date of Birth Date