CSRA RENAL SERVICES

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PATIENT CONSENT FOR RELEASE OF
PROTECTED HREALTH INFORMATION (PHI)
For treatment, Payment, and/or Healthcare Operations Purposes

PATIENT NAME: (please print)____

DATE OF BIRTH: ______/_______/________ **SOCIAL SECURITY #:** ______-_______-_______

Indicated by my signature below, I hereby request that my medical records be released:

TO: ____

____

FROM: ____

____

Requested Information:
Date(s): ___________________

☐ **Discharge Summary**	☐ **History & Physical**	☐ **Laboratory Tests**
☐ **Progress Notes**	☐ **Consultation Report**	☐ **ED information**
☐ **Radiology Report**	☐ **EKG Report**	☐ **Demographic info**
☐ **Insurance Info**	☐ **Other:**	☐ **Other:**

FOR THE PURPOSE OF: ☐ **Medical Care / Treatment** ☐ **Transfer of Medical Care**

I HEREBY RELEASE THE ABOVE NAMED PROVIDER/FACILITY RELEASING THE REQUESTED PHI FROM ALL LEGAL LIABILITY THAT MAY ARISE FROM THE FURTHER RELEASE OF THE PHIFROM MY MEDICAL RECORDS WHICH THEY ARE PROVIDING TO CSRA RENAL SERVICES, LLC PER MY REQUEST. I UNDERSTAND THAT THE PHI THAT I AM REQUESTING BE RELEASED MAY INCLUDE REFERENCE TO CONDITIONS INCLUDING PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENT, DRUG ABUSE &/OR ALCOHOLISM, SEXUAL ASSAULT, OR TEST &/OR RESULTS FROM HIV, ARC &/OR AIDS. I UNDERSTAND THAT AS PART OF CSRA RENAL SERVICES, LLC'S TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS, IT MAY BECOME NECESSARY TO FURTHER DISCLOSE THIS REQUESTED PHI TO ANOTHER ENTITY, AND I CONSENT TO SUCH DISCLOSURE FOR THESE PERMITTED USES, INCLUDING DISCLOSURES VIA FAX.

_____________________________________ _____________________________________

PATIENT SIGNATURE **DATE**

_____________________________________ _____________________________________

PARENT/GUARDIAN/LEGAL RESPRESENTATIVE (IF APPLICALE) PLEASE PRINT NAME, RELATIONSHIP, DATE

755 Medical Park Drive Aiken, SC 29801
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