Board Certified Nephrologists

Tayyab Ali, M.D.
Ravindra Bollu, M.D.
Margaret Duffy, M.D.
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Frederick S. Fleszler, M.D.
Kiran M. Goli, M.D.
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James E. Kintzel, M.D.
Nelson P. Kopyt, D.O.
Craig A Mackaness, D.O.
Sharon E. Maynard, M.D.
Deepti Moon, M.D.
Aedan S. Olaso, M.D
James P. Reichart, M.D.
M. Najum Saqib, M.D.
Henry L. Schairer, M.D.
Harinder K. Singh, M.D.
Kathryn E. Ussai, M.D.
Gregory Varghese, D.O.
Vikram Verma, M.D.
Benjamin J. Wilcox, M.D.

ABIM CERTIFIED
Yashoda Rao, M.D.
Syed Shah, M.D.

Authorization for Release of Patient Information

The information in this Authorization is confidential and protected by Federal and State Law from unauthorized use of disclosure: I, _________________________hereby authorize: ____
Individual/Facility/Program/Physician

____
Address/Telephone

To release to: ____
Individual/Facility/Program/Physician

____
Address/Telephone

Patient information regarding:
Patient Name: ____ Date of Birth: __________________________
Information to be released:
GENERAL MEDICAL RECORDS
___ Admission/discharge transcription ___ ALL RECORDS: includes all general medical records
___ All renal/kidney records/results
___ Diagnostic test results (labs, x-rays)
___ Operative Reports
___ Consultations
___ Progress Notes
___Other:(specify) ____
___Records to include behavioral health records, HIV records, and drug/alcohol records

Purpose of disclosure:
Continuity/coordination of medical care ___ Other (describe fully)
____
____

I certify that this form has been explained to me and that I understand its contents. I understand that I may revoke this consent to release information at any time in writing by sending a signed written letter to the Practice Manager of Valley Kidney Specialists, P.C., except in event that action has already been taken in relevance to it. Valley Kidney Specialists, P.C. may not condition treatment on your agreement to sign this Authorization. This consent begins on the date of signature and is valid for a period of 90 days. This information has been disclosed to you from records whose confidentiality is protected by Pennsylvania and Federal law. PA law prohibits you from making any further disclosure of information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by law. A general authorization for the release of information is not sufficient for this purpose.

____ ______________________________
Patient's Signature (or guardian/POA/personal) Date

____
Witness

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Offices in: Allentown, Bethlehem, Easton, East Stroudsburg, Kutztown, Lehighton, Phillipsburg (NJ), Pottsville, Reading, Sellersville, and Wind Gap