N. RAO BOORGU, M.D., FACP
SUBIR K. PAUL, M.D.
RAJESH BOORGU, M.D., FASN
DWIGHT MATTHEW, M.D.

SHOALS
Kidney and Hypertension
CENTER

422 East Dr. Hicks Blvd. • Florence, Alabama 35630
Phone (256) 766-1401 • Fax: (256) 766-1402

I, _____ hereby authorize **N. Rao Boorgu, M.D., P.C./Shoals Kidney and Hypertension Center** to use and/or disclose the following protected health information from:

_____

Specifically described the information to be used or disclosed. The Medical records being requested are progress notes from office visits dictated by physicians on staff, laboratory results, radiology reports, hospital care records such as history and physical admission and discharge summary, other miscellaneous medical records pertinent to referrals for additional treatment.

Other Additional Request: _____

_____

This protected health information is being used and/or disclosed for the following purpose(s).

TO EVALUATE AND TREAT PATIENT ACCORDINGLY

Other Purpose: _____

_____

_____

This authorization shall be in force and effect until the patient request in writing to discontinue, at which time this authorization 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 **N. Rao Boorgu, M.D., P.C. / Shoals Kidney and Hypertension Center, Attn: Margaret Hipps, Office Manager,** at **422 East Dr. Hicks Blvd.** in **Florence, AL 35630, Phone (256) 766-1401.** I understand that a revocation is not effective to the extent that **N. Rao Boorgu, M.D., P.C. / Shoals Kidney and Hypertension Center** 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.

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

X _____ _____

SIGNATURE OF PATIENT | NAME OF PATIENT OR PERSONAL REPRESENTATIVE (please print)

_____ _____

DATE | RELATIONSHIP TO PATIENT (or other authority to serve)