



Medical Records Department
855-812-2239 / MRHelpdesk@davita.com

FAX Completed Form to (866) 376-5824 or
Email to: MRRequest@davita.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I. **PATIENT NAME:** (Last, First, MI) _____ **DOB:** ____/____/____

I hereby authorize DaVita Inc., (DaVita) its subsidiaries and the facility(ies) listed below to disclose my protected health information:

☐ From ALL DaVita facilities where I may have treated -or- **only** the following facilities:

☐ Clinic Name: _____ Clinic No.: _____

☐ Clinic Name: _____ Clinic No.: _____

II. **I request that my protected health information (PHI) from DaVita be disclosed to:**

Recipient Name: Legal-Ease Digital Imaging, LLC

Address: 2496 Meadowcroft Dr

City: Burton State: MI Zip: 48519 Phone: 1-855-543-4003

Fax: 1-810-547-4030 E-mail Address: pat.legalease@gmail.com

III. **The information to be released is: (Please check all that apply)**

☐ Entire Medical Record ☐ Patient Registration Data ☐ Billing Records

☐ The following information: _____

Dates of Service To Include: ☒ All dates of service -or- Specific Date(s) ____/____/____ to ____/____/____

Sensitive Information (Required)

I do	I do NOT	Authorize the release of information related to:
☐	☐	Testing For or Infection with Human Immunodeficiency Virus (HIV)
☐	☐	Alcohol, Drug or Substance Abuse
☐	☐	Sickle Cell Anemia

IV. **The purpose for this release of information is:**

☐ Insurance process ☒ Legal ☐ Personal ☐ Continuation of care ☐ Disability ☐ Other _____

V. I understand the provision of healthcare treatment, payment, enrollment, or eligibility for benefits is not dependent on this authorization and I am not required to sign this authorization however, the information will not be disclosed without it. I understand that if anyone who receives my health information is not a health care provider or a health plan, federal privacy laws may no longer protect that health information.

VI. I understand I have the right to revoke this authorization in writing at any time, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by providing correspondence to the Facility Administrator of one of the facilities listed above or the Medical Records Department at fax number 866-376-5824 or 5200 Virginia Way, Brentwood, TN 37027.

VII. This authorization shall expire **90 days** from the date of signature. A photocopy is as valid as the original.

VIII. **Copy Fee Notice:** Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations of the state in which healthcare is provided.

IX. **Disclosure Format:** (CD-ROM is default if not checked) ☐ Paper ☐ CD-ROM ☒ Fax

X. _____
Patient Signature **Date**

If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the patient named above and I am not prohibited by Court Order from releasing access to the requested information.

Legal Representative Signature **Date**
(Proof of Legal Representation must accompany this request.)