Ocala Kidney Group

2980 SE 3rd Court
Ocala, FL 34471
352-622-4231 – Phone
352-622-0518 - Fax

☐ Melvin M Seek, MD	☐ Saila Ventra, MD
☐ Suresh Lakshminarayanan,	☐ Harold Locay, MD
☐ Timothy Rogers, MD	☐ Izu Nwakoby, MD
☐ Mahesh Vaghela, MD	☐ Oleksandr Kovalchuk, MD
☐ Venkat Chitumalla, MD	☐ Rebecca Ong, MD

Patients Name:_____

Telephone #: _____ Cell: _____ Date of Birth: _____

Address: _____

_____

Purpose of release (ex. Continued care, personal, etc.) _____

Release information from (organization, contact name, fax or telephone #, etc)_____

_____

Specific Items or dates needed:

☐ Cardiovascular Reports	☐ Discharge Summary	☐ History & Physical
☐ EKG Reports	☐ Radiology/X-ray reports	☐ Operative Report
☐ Lab Results	☐ Pathology Report	☐ Emergency Room:
☐ Other_____		

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health, drug and/or alcohol abuse, HIV testing/AIDS and sexually transmissible diseases.

As required by the State of Florida and federal law, Ocala Kidney Group may not use or disclose your health information, except as provided within the Health Insurance Portability and Accountability Act (HIPAA), without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

I understand that state law prohibits the re-disclosure of the information disclosed to persons/entities listed above without my further authorization, but that OKG cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

I understand that his authorization will remain in effect for one year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to OKG at the address listed above. I further understand that any such revocation does not apply to information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization. I understand that I have a right to inspect and to obtain a copy of any information disclosed.

I hereby release OKG and its employees from any and all liability that may arise from the release of the information as I have directed. I hearby authorize Ocala Kidney Group to release health information as describe d above:

Patients Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Relationship to Patient: _____