REJUVENATE
KIDNEY TRANSPLANT SOLUTIONS

31 North Summit Street
Toledo, OH 43604
Phone: 419-481-8150
FAX: 419-932-6935

HIPAA Authorization

Authorization for Disclosure of Medical Information

Patient's Name:_____Date of Birth:_____SSN: _____

Address:_____

City: _____State:_____ Zip: _____

Daytime Telephone:_____Evening Telephone: _____

E-mail address:_____

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or health care services to me or on my behalf to disclose all of my medical records in their possession, including the following, if applicable:

- My complete health record including, but not limited to, diagnosis, lab test results, treatment, and billing records for all conditions:
- Mental health records
- Communicable diseases including, but not limited to HIV and AIDS
- Alcohol and Drug Abuse Treatment records protected by 42 C.F.R. Part 2
- Records pertaining to sexually transmitted diseases
- Genetic Test Results

Mail To Rejuvenate Kidney Transplant Solutions, LLC, Susan Rees, BSN 31 North Summit Street, Toledo, OH 43604

This authorization is valid from (date)_____to the date my participation in the Rejuvenate Kidney Transplant Solutions, LLC kidney disease management program ends.

By signing below:

- I understand that Rejuvenate Kidney Transplant Solutions, LLC will share my information with healthcare providers, hospitals, the Alliance for Paired Donation and other entities for the purpose of attempting to improve the management of my kidney disease.
- I understand that I am not obligated to sign this Authorization form, that I do so voluntarily, and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. However, I understand that I will not be able to participate in the Rejuvenate Kidney Transplant Solutions kidney disease management program if I do not sign this form.
- I understand that my healthcare/insurance providers must follow federal and state privacy laws when using and sharing my information, but that other entities receiving my information pursuant to this authorization may not have to follow the same privacy laws and, therefore, may share my information with others without being subject to penalties under those laws. However, I understand that Rejuvenate Kidney Transplant Solutions, LLC will not share my information with any entity outside of their kidney disease management program, their contractors and/or the participating healthcare providers, hospitals and transplant centers without my permission.
- I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. This authorization will automatically expire when I end my participation in kidney disease management program of Rejuvenate Kidney Transplant Solutions, LLC.
- I understand that I can get a copy of this authorization form that I have signed by sending Rejuvenate Kidney Transplant Solutions, LLC a signed request using the address at the top of this form.
- I understand that Rejuvenate Kidney Transplant Solutions, LLC will be working with me to improve the management of my kidney disease. I acknowledge that Rejuvenate Kidney Transplant Solutions, LLC may identify services or opportunities to improve my healthcare condition that exceed or fall outside the coverage parameters of my current healthcare plan, and which, due to lack of coverage through my current healthcare plan,may prove cost prohibitive. I hereby waive any claims I may have against Rejuvenate Kidney Transplant Solutions, LLC now or in the future, arising out of or related to any such services.

_____ _____

Signature of Patient or Personal Representative Date

_____

If Personal Representative, source of authority to act for Patient

_____ _____

Signature of Witness Date

For this Authorization Form to be valid, it must be filled out accurately and completely.

Return this form to the HIPAA Privacy Officer, Rejuvenate Kidney Transplant Solutions,

LLC, Susan Rees, BSN 31 North Summit Street, Toledo, OH 43604 or email it to

sue@rejuvenatehealthcare.com .