



**CLEVELAND
KIDNEY
DISEASE ASSOCIATES**

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Authorization to Disclose Personal Health Information

HIPPA Supplement Form

I, _____, hereby authorize CKD Associates to disclose my
Patient Name
Health information to the following parties (family, next of kin):

Name	Address	Phone
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Name	Address	Phone
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Name	Address	Phone
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Patient Signature	/ /	Date
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Representative Signature	/ /	Date
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