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PATIENT CONSENT

Authorization to Release or Obtain Protected Patient Health Information
At the Patient's Request - Applies to release of all protected health information

Today's Date _____

Patient Full Name _____
Patient Date of Birth _____

As required by the Health Insurance Portability and Accountability Act (HIPAA), Nephrology Associates of Syracuse may not use or disclose information, except as provided in our Notice of Privacy Practices, without your authorization. I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and I may revoke it at any time. A revocation of this authorization must be submitted in writing to Nephrology Associates of Syracuse. I further understand that any such revocation applies to the extent that persons authorized to use and disclose my health information have already accepted reliance on this authorization.

By signing this form, I grant authorization to Nephrology Associates of Syracuse to:

- Release/Obtain my health information to/from any medical provider, medical staff, hospital or facility participating in my medical care or for coordination of care
- Release/Obtain my prescription drug information to/from any pharmacy, medical provider, medical staff, hospital or facility participating in my medical care or for coordination of care
- Release/Obtain my health information to/from the following members of my family or other individuals specified by me as listed below:

Name of Individual we can share information with: _____
Address: _____
Relationship: _____
Phone #: _____

Name of Individual we can share information with: _____
Address: _____
Relationship: _____
Phone #: _____

Description of health information to be released: ___ all ____specifically _____
Expiration Date of Authorization: ____ continuous _____ until enter specific date _____
This authorization expires upon release of requested information unless otherwise stated. Please mark continuous if you do not wish it to expire.