STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

Durham Nephrology Associates, P.A.

Information to be Used or Disclosed
The information covered by this authorization includes:

____
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____

Purpose of the Disclosure: ____

Will this information be used for marketing? Yes____ No X

Has this information been previously de-identified? Yes____ No X

Persons Authorized to Use or Disclose the Above Information: ______________________
Durham Nephrology Associates, P.A.
____
(Name of person or organization)

Person(s) to Whom Information May Be Disclosed: ______________________
____
(Name of person or organization)

Expiration Date or Event of Authorization: This authorization will expire on ____/____/____(Date); or when this occurs ______________________________ (Event). I understand that I can revoke this authorization at any time by submitting a written request. I understand that revocation will not affect actions taken prior to our receipt of any revocation request.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

____
Name of patient (Type/Print)

____
Signature of Patient Date

____
Signature of Patient Representative (if applicable)

____
Relationship of Patient Representative to Patient (if applicable)