Durham Nephrology Associates, pa

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

PLEASE PRINT CLEARLY

INFORMATION TO BE USED OR DISCLOSED

The information covered by this authorization includes:

All Medical Records

Purpose of the Disclosure:

Will this information be used for marketing? ☐ Yes ☑ No

Has this information been previously de-identified? ☐ Yes ☑ No

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 or Print)

Signature of Patient Date

Signature of Patient Representative (if applicable)

Relationship of Patient Representative to Patient (if applicable)

>>>>>>>> TURN OVER >>>>>>>>

Durham Nephrology Associates, pa

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

PLEASE PRINT CLEARLY

A Notice of Privacy Practices (NPP) is provided to all patients. The Notice of Privacy Practices identifies: 1) How medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices, and is a patient or the patient's personal representative.

* _____ * _____

Name of Patient | Signature of Patient

* _____ / _____ / _____

Date Signed

_____ _____

Name of Patient's Personal Representative | Signature of Patient's Personal Representative

_____ / _____ / _____

Date Signed

FOR INTERNAL USE ONLY

_____ _____

Name of Employee | Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

☐ Patient was unable to sign.

☐ Patient refused to sign.

☐ Other_____

_____ / _____ / _____ (Date: As noted on NPP)