NEPHROLOGY ASSOCIATES
delawarekidney.com

# REVIEW OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
# AUTHORIZATION TO DISCLOSE PATIENT INFORMATION

Your privacy is important to us. By signing this form, you are acknowledging that you have reviewed the Notice of Privacy Practices of Nephrology Associates, P.A., which outlines how Nephrology Associates, P.A. may use and disclose your protected health information. I am aware that I can go to the www.delawarekidney.com website to get a copy of the notice or request one at any time.

**Below please identify those individual(s) to whom we may release information or speak with on your behalf.**

## AUTHORIZATION TO RECEIVE MY MEDICAL INFORMATION

**Nephrology Associates, P.A. may disclose my personal health information to the following:**

- ❑ Myself ❑ My legal representative _____
- ❑ Spouse _____ ❑ Child(ren) _____
- ❑ Relative _____ Relationship _____
- ❑ Relative _____ Relationship _____
- ❑ Other _____ Relationship _____
- ❑ Other _____ Relationship_____

I understand that I may revoke this authorization at any time by providing written notice to Nephrology Associates, P.A**.** This authorization cannot be revoked to the extent that action has already been taken in reliance on the authorization.

Nephrology Associates, P.A. will not use or disclose personal health information beyond the scope of this authorization without my written consent or authorization. I understand that the recipient(s) I designated above may disclose my private health information. Should this occur, I will not hold Nephrology Associates, P.A. responsible.

➔_____ _____←
**Signature of Patient or Patient's Legal Representative** **Date**

➔_____ _____←
**Print Patient's Name** **Relationship** (if signed by person other than patient)

➔_____
**Patient's Date of Birth**

FOR NEPHROLOGY ASSOCIATES PA USE ONLY

**Inability to Obtain Acknowledgement**

**To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain their acknowledgement, and the reasons why it was not obtained:**

Comments:

**Signature of Nephrology Associates PA representative:_____ Date:_____**

**Patient MR#_____**