PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Ocala Kidney Group to disclose certain protected health information (PHI) about me to the following recipients:

1. _____
2. _____
3. _____

Ocala Kidney Group may also leave messages on my home voice messaging system, my cell voice messaging system, or any other voice messaging system that I might indicate as a valid means of communication. I also authorize them to leave messages with the designated above named person (s) The information may be left relating to appointment scheduling, re-scheduling or any relevant changes.

This authorization will not expire unless I request in writing that it be changed.

I do not have to sign this authorization in order to receive treatment from Ocala Kidney Group. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy and Security Officer.

❑ Yes, please leave a message ❑ No, do NOT leave any detailed message

Signed by: _____

Relationship to patient: _____

Patient's name: _____

Date: _____

Print name of patient or legal guardian: _____

❑ Patient/Guardian REFUSED signature _____ Staff witness (initial)