RNA
Rockford Nephrology Associates

ROCKFORD NEPHROLOGY ASSOCIATES
RNA of Rockford, LLC
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

PATIENT INFORMATION

Patient Name (Last, First, Middle) _____

Date of Birth: ___/___/___ ○Male ○Female Primary Nephrologist: _____

What is the best phone number to use during the day / office hours? ○Home ○Cell ○Work ○Other

Home Phone: (___) _____ May we leave a message? ○Yes ○No

Cell Phone: (___) _____ May we leave a message? ○Yes ○No

Work / Other Phone : (___) _____ May we leave a message? ○Yes ○No

CONSENT

I have read, understand and a copy has been made available to me of RNA's patient privacy notice which describes how medical information about me may be used and disclosed and how I can get access to this information. I understand that the physician has reserved a right to change his or her privacy practices. I understand that a copy of any revised notice will be available to me at the physician's office location.

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE LISTED BELOW.

Patient Name (print): _____

Signature: _____ Date: _____

Sign/Date: _____ Sign/Date: _____

Sign/Date: _____ Sign/Date: _____

If you are not the patient, please specify your relationship to the patient: _____

CONTACT PERSON / PEOPLE

Please list anyone involved with your healthcare that you would like to have access to your medical information here at Rockford Nephrology Associates. This should include any person who may contact our office on your behalf, or accompany you during your visit(s). You may attach a list if more space is necessary.

Name: _____ Phone Number: _____

May we leave a message? ○Yes ○No Relationship: _____ Power of Attorney/POA? _____

Grant Full PHI Access? ○Yes ○No If no, explain reason for limited access: _____

Name: _____ Phone Number: _____

May we leave a message? ○Yes ○No Relationship: _____ Power of Attorney/POA? _____

Grant Full PHI Access? ○Yes ○No If no, explain reason for limited access: _____