Dallas Renal Group

Individual Patient's Authorization

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

I, _____ give my authorization to use or disclose my protected
(Patient's Name)
health information to the following individual(s) or group(s).

THIS SHOULD BE NAMES OF RELATIVE OR FRIENDS WE MAY DISCUSS YOUR HEALTH ISSUES WITH. YOU SHOULD LIST AT LEAST ONE PERSON WHO HELPS YOU WHEN YOU ARE ILL.

_____ _____

_____ _____

I authorize Dallas Renal Group or their representative to leave messages via the following: **Please number in order of preference.** If you don't want to be contacted by one of the following, do not place a number by it.

_____ Home answering machine

_____ Work voice mail

_____ Cell phone

_____ Text message

_____ EMAIL _____

I understand that I may revoke this authorization at any time and understand this must be done in writing.

This authorization will end only upon written notice. You must make any additions or deletions from this list in writing.

Name (Print): _____

Signature: _____

Date: _____

This must be completed for ANY information to be disclosed to a spouse, family member, organization, or individual that assists you with your medical care, appointments, or insurance.