NCN | NORTH CAROLINA NEPHROLOGY, P.A.

1-877-NCN-NCN9 (1-877-626-6269)

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's Name: ____
First MI Last

Date of Birth: ____________________ Soc Sec #: ____________________

Authorized Individual/Organizations:

Name: ______________________________ Relationship: ____________

Address: ______________________________ Phone: ____________

Name: ______________________________ Relationship: ____________

Address: ______________________________ Phone: ____________

Name: ______________________________ Relationship: ____________

Address: ______________________________ Phone: ____________

This request and authorization applies to: □ All healthcare information.

□ Healthcare information relating to the following treatment, condition, or dates: ____________

____

Other: ____

Definition: I understand that authorizing the disclosure of this health information is voluntary. I can revoke this authorization at any time. To revoke, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

______________________________ ____________

Patient Signature Date