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