NEW ORLEANS NEPHROLOGY ASSOCIATES, LLC

Metabolic Bone and Stone Center • Nephrology • Hypertension

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a healthcare provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Patient Name:_____ Date of Birth:_____

Persons/Organizations authorized to release the information:_____

Persons/Organizations authorized to receive the information:_____

Specific description of information (including dates[s]):_____

_____

I hereby authorize New Orleans Nephrology Associates, LLC, (NONA) personnel to leave a detailed message, i.e., lab/ testing results/ appointment information, on my answering machine:

Patient Signature:_____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on:_____ Initials:_____

2. I understand that I may revoke this authorization at any time by notifying NONA, in writing, but if I do revoke this authorization, my revocation will not have an effect on any actions taken by NONA in reliance upon my authorization before it received my revocation. Initials:_____

You may revoke this authorization by signing a Revocation of Authorization form and returning it. To request a Revocation of Authorization form, you may contact New Orleans Nephrology Associates, LLC, 4409 Utica Street, Suite 100, Metairie, LA 70006, (504) 457-3687, Terry A. Caluda, Practice Manager.

3. I understand that my revoking this authorization form will not condition my treatment or payment for my healthcare services on your completing and signing this authorization.

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Section B: Must be completed when New Orleans Nephrology Associates, LLC requests the authorization for its own use or for another covered entity to disclose information to New Orleans Nephrology Associates, LLC, for treatment, payment, or healthcare operations purposes.

To be completed by New Orleans Nephrology Associates, LLC.

1. The purpose of this disclosure is:_____

2. NONA ☐ will ☐ will not receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: You or your representative may inspect and/or copy the health information in accordance with the policies.

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Section C: Must be completed for all authorizations:

I have received a copy of New Orleans Nephrology Associates, LLC's Notice of Privacy Practices.

Patient Name:_____ Patient Social Security Number:_____
(Please Print)

_____ Date:_____
(Signature of Patient or Patient's Representative)

_____ _____
(Printed Name of Patient or Patient's Representative) (Relationship to Patient)