NEW ORLEANS NEPHROLOGY ASSOCIATES, LLC

Metabolic Bone and Stone Center • Nephrology • Hypertension

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HIPAA MEDICAL AUTHORIZATION

Patient Name:_____ Date of Birth:_____

Previous Name:_____

I. **I hereby authorize Dr. _____ to disclose my health care information.**

II. **You may use or disclose my medical information to:**

1. Name of person(s) or organization:_____

   Address:_____ City _____ State_____

   Relationship:_____

2. Name of person(s) or organization:_____

   Address:_____ City _____ State_____

   Relationship:_____

III. **I prefer to be contacted by:**

Home Phone Number:_____

Cell Phone Number:_____

Other:_____

IV. **You may leave medical information regarding the call on my:**

Home Voice Recorder:_____

Cell Phone Voice Message:_____

No messages allowed:_____

Other:_____

V. You may leave the following medical information:

Appointment Information:_____

Lab result/information/instructions:_____

Medication information:_____

VI. Purpose of this authorization

☐ At my request

☐ Other:_____

☐ Check here when New Orleans Nephrology Associates, LLC, requests the authorization for marketing purposes.

☐ Check here when New Orleans Nephrology Associates, LLC, will get something of value for providing health information for marketing purposes.

VII. This Authorization ends:

☐ On (date):_____

☐ When the following event occurs:_____

VIII. My Rights:

- I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, enrollment or eligibility). However, I do have to sign an authorization form to take part in a research study or to receive healthcare when the purpose is to create health information for a third party.
- I may revoke this authorization in writing by sending a letter to the healthcare provider to which the authorization is directed. If I do this, it will not affect any actions already taken by the healthcare provider based upon this authorization.
- I may not be able to revoke this authorization if its purpose is to obtain insurance.
- I understand that once the healthcare provider discloses my health information, the person or entity that receives it may re-disclose it. The HIPAA Privacy laws may no longer protect it.

_____ _____
Patient Name (Print) Date

_____
Patient Signature

_____
Guardian/Individual legally authorized to sign on behalf of Patient