Authorization for Release of Information – Compound Release

Patient _____ Date of Birth _____

Durham Nephrology Associates, PA is authorized to release protected health information about the above named patient in the following manner.

Patient Primary Contact Number	**Email Address for Patient Portal FollowMyHealth**
_____	_____
Primary Emergency Contact (name, address and phone number) _____ _____ _____	Contact (name, address and phone number) _____ _____ _____
Contact (name, address and phone number) _____ _____ _____	Contact(name, address and phone number) _____ _____ _____
Contact(name, address and phone number) _____ _____ _____	Contact(name, address and phone number) _____ _____ _____
Contact(name, address and phone number) _____ _____ _____	Contact(name, address and phone number) _____ _____ _____

✓You are authorizing that each contact listed above may receive any medical or financial information concerning you.

Patient Rights:

- I have the right to revoke this authorization at any time.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ Date _____

Signature of Patient or Personal Representative*

_____

*Description of Personal Representative's Authority (attach necessary documentation)

Revised April 2015