DURHAM NEPHROLOGY ASSOCIATES, PA
PATIENT INFORMATION and AUTHORIZATION FORM

Patient: _____**Birthdate:**_____

Address: _____

Social Security: _____-_____-_____ **Sex:** Male or Female

Phone Number: Home_____Work_____Cell_____

Marital Status: ○Single ○Married ○Widowed ○Divorced ○Separated ○Other

Race: ○Black/African American ○Caucasian ○American Indian/Alaska Native

○Asian ○Native Hawaiian ○Other Pacific Islander ○More Than One Race

Employed: ○Yes ○Not Employed ○Disabled ○Retired

Primary Care Doctor: _____

Referring Doctor: _____

Spouse's Name: _____ **Birthdate:** _____

I hereby authorize Durham Nephrology Associates, PA to release or obtain any protected or individually identifiable health information to other Providers, Facilities, or Individuals involved with my treatment or the payment thereof, as described in the privacy policies statement of Durham Nephrology Associates. I am aware that records may be obtained either by mail, fax or electronically from physicians or hospitals that share in my medical care.

I also request that payment of authorized Medicare/Medigap/Medicaid/other insurance company benefits be made directly to Durham Nephrology Associates, PA for any service furnished to me, and hereby assign said benefits to them. I understand that I am required by law to inform Durham Nephrology Associates of any other party that may be responsible for payment of services that are provided to me.

I understand that it is the policy of Durham Nephrology Associates to collect co-payments at the time of service.

I understand that this authorization will remain valid until revoked in writing.

_____

(Signature of Patient or Personal Representative) (Date)

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