NAMV NEPHROLOGY ASSOCIATES OF THE MERRIMACK VALLEY

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PATIENT AUTHORIZATION FORM

Because of the changes made by Congress, we are required to get your explicit permission regarding how your medical information is handled.

A copy of the Notice of Privacy Practices will be provided to all patients by our staff. Please read each authorization carefully and indicate your approval by initialing on the line provided.

I authorize the release of all medical records maintained by Nephrology Associates of the Merrimack Valley, which relates to services I have received from, or the results of tests ordered by Nephrology Associates of the Merrimack Valley. These records may be released as needed for my care for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipating litigation under a worker's compensation, motor vehicle accident, and/or third-party liability claim. Initials: _____

I am giving permission for Nephrology Associates of the Merrimack Valley to obtain my prior films, scans, labs, and any records that relate to services provided. I understand that it is my responsibility to obtain previous studies, if asked to do so. If it is necessary for an employee of Nephrology Associates of the Merrimack Valley to obtain my prior films, labs, and/or other records, I am giving my permission to call and/or fax on my behalf to get needed medical records and films. Initials: _____

I authorize direct payment of benefits from my insurance plan to Nephrology Associates of the Merrimack Valley. I understand that I am responsible for payment of professional fees charged by Nephrology Associates of the Merrimack Valley, which are not covered or not properly reimbursed under the terms of my insurance plan. Initials: _____

I will provide Nephrology Associates of the Merrimack Valley with the phone numbers I authorize to be used to contact me. I authorize the use of any messaging person or system, voice mail and/or answering machine to convey information regarding my care. Initials: _____

I authorize the use of fax or e-mail to send my information to myself or other parties that have a right to receive my information. I understand that every effort is made to protect my privacy; however, no absolute privacy guarantee is given when faxes or e-mails are used. Initials: _____

I understand that it is my right to request limited access to my records and to withdraw permission for the release of my records. I understand that this request must be in writing and that limiting or withdrawing my permission may result in Nephrology Associates of the Merrimack Valley discontinuing its relationship with me. In that case, I will need to seek care from another source.

_____ _____
SIGNATURE DATE

I have been offered a copy of Nephrology Associates of the Merrimack Valley's Notice of Privacy Practices for my own records.

Initials: _____

My signature above also gives my permission and consent for any and all medical information maintained in or generated by Nephrology Associates of the Merrimack Valley on my behalf to be released and/or discussed with the following person(s):

_____ _____ _____
PATIENT'S FAMILY MEMBER'S NAME RELATIONSHIP TO PATIENT TELEPHONE NUMBER

PATIENT'S PRINTED NAME: _____ DOB: _____

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