DALLAS RENAL GROUP
Leaders in Kidney Care

Individual Patient's Authorization

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

I ________________________ give my authorization to use or disclose my protected
(Patient's Name)
health information to the following individual(s) or group(s).

THIS SHOULD BE NAMES OF RELATIVE OR FRIENDS WE MAY DISCUSS YOUR HEALTH ISSUES WITH. YOU SHOULD LIST AT LEAST ONE PERSON WHO HELPS YOU WHEN YOU ARE ILL.

________________________________ ________________________________

________________________________ ________________________________

I authorize Dallas Renal Group or their representative to leave messages via the following: **Please number in order of preference.** If you don't want to be contacted by one of the following, do not place a number by it.

______ Home answering machine

______ Work voice mail

______ Cell phone

______ Text message

______ EMAIL ____

I understand that I may revoke this authorization at any time and understand this must be done in writing.

This authorization will end only upon written notice. You must make any additions or deletions from this list in writing.

Name (Print): ____

Signature: ____

Date: ____

This must be completed for ANY information to be disclosed to a spouse, family member, organization, or individual that assists you with your medical care, appointments, or insurance.