SOUTHWEST ATLANTA NEPHROLOGY, P.C.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Southwest Atlanta Nephrology, P.C. to use and/or disclose certain protected health information (PHI) about me to _____.
Name of entity to receive this information

This authorization permits Southwest Atlanta Nephrology, P.C. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

_____

The information will be used or disclosed for the following purpose:

_____.

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.
{Expiration Date or Defined Event}.

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Southwest Atlanta Nephrology, P.C.. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in

reliance upon this authorization. My written revocation must be submitted to the Privacy Official at:

Southwest Atlanta Nephrology, P.C.
3620 MLK, Jr., Drive, S.W.
Atlanta, GA 30331

RESEARCH APPROVAL:

Under certain circumstances, we may use and disclose your medical information for research purposes. All research projects are subject to approval by a central Institutional Review Board, which must review and approve our established research protocols for protecting the privacy of your health information. To participate in a given research project, we must obtain your express written authorization. Please be aware that other individuals associated with the research protocol will have access to your medical records, including study staff, pharmaceutical sponsors and the Food and Drug Administration.

I (initial one) _____ _____
Approve Do Not Approve

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION