RENAL ASSOCIATES, P.A.

AUTHORIZATION AND CONSENTS

Initials	Authorization for Release of Medical Records
____	I authorize Renal Associates, P.A., to release any medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, continuity of care, and medical treatment.
Initials	**Consent for Treatment**
____	As an adult and/or legal guardian, I do agree to permit the physicians and/or clinical staff at Renal Associates, P.A., to provide medical care to myself, my child, or the patient I represent as applicable. By signing below, I do agree to permit the physician and/or clinical staff to perform necessary or appropriate medical care including physical examinations, diagnosis, and treatment.
Initials	**Assignment of Benefits**
____	I hereby do authorize payment directly to Renal Associates, P.A., for medical benefits otherwise payable to me. I do authorize my insurance company and/or the social security administration (Medicare) to disclose to Renal Associates, P.A., information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third party payor.
Initials	**Notice of Privacy Practices Acknowledgment**
____	Your name and signature on this sheet indicate that you have read and have been offered a copy of the Renal Associates, P.A Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Renal Associates Practices, please do not hesitate to contact a clinic representative or our Privacy Officer as indicated on your Notice.
Initials	**Release of Data**
____	I GIVE CONSENT to ALL of the Participating Providers to access ALL of my electronic health information through my designated insurance carriers Health Information Exchange (HIE) in connection with providing me any health care services, including emergency care and I GIVE CONSENT to the HIE to access ALL of my electronic health information through the HIE in connection with providing me any health care services, including emergency care.
Initials	**Release of Information**
____	In addition, your name and signature below represent your Request and Authorization for Renal Associates, P.A. to disclose information as specified by you the patient as noted in this Authorization: Do you authorize a family member or other person identified by you, the patient, to have access to your medical records/information? **YES or NO (PLEASE CIRCLE)** **If YES, please specify family member or other person names that you authorize to your medical records and information:** Name: _____ Relationship _____ Phone _____ Name: _____ Relationship _____ Phone _____

I have read and fully understand the Authorization for Release of Medical Records, Consent for Treatment, Assignment of Benefits, and Notice of Privacy Practices.

Print Patient Name:_____ Birth Date: _____

Signature of Patient or Legal Guardian:_____ Date: _____

Relationship of Patient:_____

Witness Signature: _____ Date: _____