GEORGIA RENAL ASSOCIATES

Patient Consent for Use/Disclosure of Health Care Information

PLEASE READ AND SIGN THIS FORM

Patient Name: _____ Date of Birth: _____

I understand that my health information is private and confidential. I understand that Georgia Renal Associates, (GRA) works very hard to protect my privacy and preserve the confidentiality of the personal health information.

I understand that GRA may use and disclose my personal health information (PHI) to help provide healthcare to me, to handle billing and payment, and to take care of the other health care operations. I give consent for my treating physicians and other health care providers to exchange information with other health care professionals and providers (for example physicians, consultants, hospitals, nursing homes, home health agencies and pharmacies) about my prior and current health conditions to facilitate treatment.

I understand that GRA participates in clinical trials and clinical research. From time-to-time GRA may use my anonymized clinical data for research purposes. For all other research related information disclosure GRA will request authorization from me.

In general, there will be no other uses and disclosures of this information unless I authorized it in writing. I understand that sometimes law may require release of information without my permission. These situations are very unusual.

GRA has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting our patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. GRA may update this ''Notice of Privacy Practices" at any time. If I ask, GRA will provide me with the most current ''Notice of Privacy Practices".

Our notice of Privacy Practices states that we may disclose your PHI to others who may assist in your care, such as your spouse, children, parents or caregiver. **Please list any family members and caregivers with whom we are authorized to discuss your medical care or to whom we may release medical records.**

Person	**Relationship to Patient**

☐ Do not release to family/caregivers. If you wish to RESTRICT use/disclosure in other ways please speak to front desk staff.

Under the terms of this consent, I can ask GRA to limit how my personal health information is used or disclosed to carry out treatment, payment or health care options. I understand that GRA does not have to agree to my request. If GRA does agree to my request, I understand that they would follow the agreed limits.

I may cancel this consent in writing at any time by writing, signing, and dating a letter to GRA. The letter must say that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment and health care operations. If I revoke this consent, GRA does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of GRA's "Notice of Privacy Practices". My signature means that I agree to allow GRA to use and disclose my personal health information to carry out treatment, payment and health care operations.

Patient or legally authorized individual signature Date

Relationship to patient if signed by anyone other than the patient Date