NEPHROLOGY ASSOCIATES

Patient Contact – Outpatient Visit

Permission to Release Protected Health Information (PHI) by Telephone

Nephrology Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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(Patient First Name) (Patient Middle Initial) (Patient Last Name) (Date of Birth)

The reason for this release is to allow Nephrology Associates to provide me with the timely information about my health care and bills. Nephrology Associates will not discuss any information considered sensitive with my contact. This authorization does not allow Nephrology Associates to release copies of my Protected Health Information (PHI) to anyone.

Note: Nephrology Associates may contact you concerning appointments, insurance, billing and payment, treatment, care instructions, and other benefits and services. We may leave detailed messages at your home or voicemail. We may send you text and email messages at numbers and addresses you give to us even if you do not sign this form.

☐ **Yes** I give Nephrology Associates permission to leave detailed messages. I know they may communicate detailed protected health information (PHI) known about me now and in the future.

A detailed message may be left on my voicemail, or with any person that answers at the phone number listed below:

PHI that may be discussed and/or in messages include:

- Appointment reminders (provider name and department)
- Billing or payment information
- Test and procedure results

Preferred Phone Number: (______) - ______ - _________
(Area code) (phone number)

Type of Phone: ☐ Home ☐ Mobile ☐ Work ☐ Other

Only leave a detailed message on voicemail or with the following person at the preferred phone number listed above.
Full Name: ____ Relationship: ____________________________

☐ **I Decline.** Do not leave detailed messages.

I understand that information may be communicated about me. This reflects my wishes. I give permission to Nephrology Associates to use the information I have provided on this form.

X____

(Patient or Legal Guardian/Representative Signature) (Date) (Time)

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(If not the patient, list relationship to patient)