

# **Fredericksburg Nephrology Associates Inc.**

101 Park Hill Drive  
Fredericksburg, VA 22401  
540-371-3010

Pogonia Medical Arts Building  
4604 Spotsylvania Parkway Suite#335  
Fredericksburg, VA 22408

## **Acknowledgement of Notice of Privacy Practices**

I have been presented with a copy of the Notice of Privacy practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship (If not signed by patient) \_\_\_\_\_

## **Disclosure of Protected Health Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

{ } I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

{ } Spouse/Significant Other \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

{ } Child(ren) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

{ } Other \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

{ } I authorized those listed above to sign on my behalf as needed.

{ } Information is not to be released to anyone

This **Disclosure of Protected Health Information** will remain in effect until terminated by me in writing.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

### **Right to Terminate or Revoke Authorization**

You may terminate or revoke this authorization in writing at any time by sending written notification to Fredericksburg Nephrology Associates Inc. at 101 Park Hill Drive Fredericksburg VA, 22401. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

Date \_\_\_\_\_

Name of Patient or Patient Representative (Please print) \_\_\_\_\_

Signature of Patient or Patient representative \_\_\_\_\_