



**STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI & HIE**

**Premier Renal Care Associates** participates in one or more Health Information Exchange (HIE). As your healthcare provider, we may appropriately access your health information electronically, as well as securely share your health information with other health information exchange participants. For example, if you see one of our physicians and then visit a hospital that participates in the HIE, that hospital would be able to access your Premier Renal Care Associates medical chart information. This is a voluntary agreement. You may opt-out at any time by notifying our office.

**Person(s) to whom the Information may be Disclosed:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

**Is this person able to receive your Personal Health Information?**    Yes    No

**Is this person able to receive your Personal Health Information?**    Yes    No

**Right to Terminate or Revoke Authorization:**

I understand I can revoke this authorization at any time by submitting a written request. I understand that revocation will not affect actions taken prior to our receipt of any revocation request.

**What is your preferred contact number for appointment reminders and messages?**

Preferred Phone#: \_\_\_\_\_

**What is your preferred time of day for appointment reminders and messages?**

Morning     Afternoon     Evening

**Would you like to be web enabled for our patient portal?**     Yes     No

If yes please provide your email address \_\_\_\_\_

**On occasion, we may need to call you and leave information regarding results of any treatments or tests that you have had. May we leave this information on your voicemail?**     Yes     No

If yes, please circle preference:    Home Phone or Cell Phone        Brief or Extended   

For us to service our account or to collect any amounts you may owe, we, as well as any agency contracted by us, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We, as well as any agency contracted by us, may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I, \_\_\_\_\_ do hereby acknowledge notification of the Notice of Privacy Practices, Policies, and Procedures.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_