Nephrology Associates
OF TIDEWATER, LTD.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name:_____ Date of Birth (MM/DD/YYY):_____/_____/_____

☐ I authorize the release of my protected health information to the following individuals who may be involved with or responsible for my care:

☐ Spouse/Significant Other:_____ Phone _____

☐ Child(ren)_____ Phone _____

_____ Phone _____

☐ Other _____ Phone _____

☐ 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 Nephrology Associates of Tidewater, Ltd., 6160 Kempsville Circle, Suite 302A, Norfolk, VA 23502. 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.

Signature _____ Date_____

Relationship (If not signed by patient)_____