Dallas Nephrology Associates

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Dallas Nephrology Associates originates records and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health information may be used or disclosed by Dallas Nephrology Associates for treatment, payment, and health care operations. For example, my health information serves as:

- A basis for planning my care and treatment;
- A means of communication among other health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payor can verify that services billed were actually provided;

I acknowledge that I have been provided with Dallas Nephrology Associates' Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Dallas Nephrology Associates reserves the right to change its Notice of Privacy Practices at any time and that I will be provided a copy of the revised Notice of Privacy Practices.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that Dallas Nephrology Associates is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

I understand that I may revoke this consent in writing, except to the extent that Dallas Nephrology Associates has already taken action in reliance thereon.

By signing this form, I consent to Dallas Nephrology Associates' use and disclosure of my health information for treatment, payment, and health care operations.

☐ I request the following restrictions to the use or disclosure of my health information:

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☐ Restrictions Accepted ☐ Restrictions Denied

Print Patient Name ____

Signature of Patient/Patient Representative ______________________________Date ______________

June 2013