NEPHROLOGY HYPERTENSION ASSOCIATES, P.C.
PATIENT REGISTRATION MEDICAL HISTORY FORM

CONSENT TO TREATMENT AND RELEASE OF MEDICAL RECORDS - PLEASE READ AND SIGN

I _____ Consent to the care of the above named patient.

- I verify that this information regarding the medical history of the above named patient is correct.
- I authorize the release of medical records to the referring and family physicians.
- I authorize the release of medical records to my insurance company.
- I allow fax transmittal of my medical records.

I have read and understand the above consent for treatment and release of information.

SIGNATURE:_____ DATE:_____

ALTERNATIVE PERSONS TO CONTACT AND SPEAK WITH REQUARDING MEDICAL TREATMENT

NAME	RELATIONSHIP	PHONE NUMBERS
_____	_____	_____
_____	_____	_____
_____	_____	_____

VOICE MAIL AUTHORIZATION

I, _____, recognize that timely delivery of results of tests or other communication of health care information is important to the delivery of quality health care. Therefore, I understand that there may be times when it is more efficentand/or effective to receive information telephonically. In order to allow for the free-flow of such information, the following acknowledgement is exucuted.

My signature below acknowledges that it is permissible for the members of this practice to communicate medical information to me by calling me at the following number:_____. If I do not answer and a voice mail system or answering machine is **indicated, the practice is** authorized to leave information related to my medical condition on that system. I realize that this may mean that others that are in the vacinity of the system or machine or that have access to it may have access to an audio transmission of my private health care information. However, the risk of any such incidental discloser is so small and/or I do not have such privacy concerns in my household, that the benefits of efficient delivery of my healthcare information significantly outweighs any risks involved.

This authorization does not apply to the release of records related to psychotherapy, HIV or drug and alcohol testing, which are subject to more protections afford by state law.

I recognize that I have the right to revoke this authorization at any time by calling the practice. Also, this authorization only allows for such communication that is related to past, present or on going treatment of me. Any authorizations required by the privacy role issued as a result of the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") that are for the release of information to someone other than myself will require a separate authorization form and is not incorporated into this document.

I aknowledge and understand the above:

_____ _____

Signature of Patient/Legal Guardian/Legal representative Date

_____ _____

Name of Personal representative Relationship to Patient

PATIENT NAME:_____ DATE OF BIRTH:_____