

# Dallas Renal Group

## Individual Patient's Authorization

**THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.**

I, \_\_\_\_\_ give my authorization to use or disclose my protected  
(Patient's Name)  
health information to the following individual(s) or group(s).

**THIS SHOULD BE NAMES OF RELATIVE OR FRIENDS WE MAY DISCUSS YOUR HEALTH ISSUES WITH. YOU SHOULD LIST AT LEAST ONE PERSON WHO HELPS YOU WHEN YOU ARE ILL.**

_____	_____
_____	_____
_____	_____

I authorize Dallas Renal Group or their representative to leave messages via the following:

- \_\_\_\_\_ Home answering machine
- \_\_\_\_\_ Work voice mail
- \_\_\_\_\_ Personal cellular phone
- \_\_\_\_\_ Other \_\_\_\_\_

I understand that I may revoke this authorization at any time, and understand this must be done in writing.

This authorization will end only upon written notice. You must make any additions or deletions from this list in writing.

Name (Print): \_\_\_\_\_

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

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

**This must be completed in order for ANY information to be disclosed to a spouse, family member, organization, or individual that assists you with your medical care, appointments, or insurance.**