

**NEPHROLOGY ASSOCIATES OF SYRACUSE, P.C.**

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Dorothy L. Schneider,  
CPAM, Chief Operating  
Officer

**Authorization for Release of Information for Purposes Requested by Physician’s Office  
from Another Covered Entity**

I, \_\_\_\_\_, hereby authorize Nephrology Associates of  
Syracuse, P.C. to disclose the following protected health information to:

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(Specifically describe the information to be used or disclosed, including, but not limited to,  
meaningful descriptors such as date of service, type of service provided, level of detail to be  
released, origin of information, etc.)

This protected health information is being used or disclosed to carry out treatment, payment  
and/or health care operations of Nephrology Associates of Syracuse, P.C. in the following  
manner: (list specific purposes here)

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This authorization shall be in force and effect while you are an active patient with this practice.

I understand that information used or disclosed pursuant to this authorization may be subject to  
redisclosure by the recipient and may no longer be protected by federal or state law.

Nephrology Associates of Syracuse, P.C. will not condition my treatment, payment, enrollment  
(if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the  
requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted  
under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

I have signed a consent form of Nephrology Associates of Syracuse, P.C. and have been made aware of the Practice's "Notice of Privacy Practices." The statements included in this authorization are binding on the Nephrology Associates of Syracuse, P.C.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Nephrology Associates of Syracuse, P.C. from a third party.

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

Print name of patient: \_\_\_\_\_

If you are signing as the patient's representative:

Print your name: \_\_\_\_\_

Describe your authority: \_\_\_\_\_

### REVOCATION

**I hereby revoke the consent given above.**

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

Print name of patient: \_\_\_\_\_

If you are signing as the patient's representative:

Print your name: \_\_\_\_\_

Describe your authority: \_\_\_\_\_

Address of revocation: Your revocation will be effective when it is received at the following address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This consent may be combined with the informed consent, as long as it is visually and organizationally separate, and separately signed and dated.