NRC DNP Telehealth LLC

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HIPAA Privacy and Release of Information Authorization

I, _____, disclose to NRC DNP Telehealth LLC, my protected health information listed below: ☐All health information ☐Physician's Orders ☐Progress Notes ☐Pathology reports ☐History/Physical Exams ☐Patient Allergies ☐Discharge Summary ☐Billing Information ☐Past/Present Medications ☐Operation Reports ☐Diagnostic Test Reports ☐Radiology Reports & Images ☐Lab Results ☐Consultation Reports ☐EKG/Cardiology Reports ☐Other

The purpose of disclosure shall be for treatment/continuing medical care, billing or claims, Insurance in addition to: ☐ Personal Use ☐ Legal Purposes ☐ Disability Determination ☐ School ☐ Employment ☐ Other

Your initials are required to release the following information:

_____Drug, Alcohol, or Substance Abuse Records _____HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient Printed Name _____

_____ _____
Signature Date and Time

Signature of Individual or Individual's Legally Authorized Representative
Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐Parent of minor ☐Guardian ☐Other _____