NEPHROLOGY OF THE GOLDEN ISLES
3025 Shrine Rd, Suite 270 Brunswick, GA 31520
Phone : (912)262-2723 Fax: (877)244-5666

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11)

ATTENTION: If English is not your primary language, free language assistance services are available to you. Auxiliary aids and services are available to provide information in accessible formats for individuals with vision and hearing disabilities, also free of charge. Speak to your provider for more information.

Español
ATENCIÓN: Si el inglés no es su idioma principal, tiene a su disposición servicios gratuitos de asistencia lingüística. También hay ayudas y servicios auxiliares disponibles para proporcionar información en formatos accesibles para personas con discapacidades visuales y auditivas, también sin cargo. Hable con su proveedor para obtener más información.

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Office Hours are by Appointment

Monday thru Friday 8:00AM to 5:00PM

If you see you are going to be more than 15 minutes late, please call**. If you cannot make your scheduled appointment, please call 24 hours in advance to avoid a $25.00 no show charge to your account**. This time has been set aside especially for you. There are a limited number of patients that can be seen on a daily basis.

Medical information

We would appreciate it if you would complete or update any medical information forms as completely as possible, checking both sides of the page. **You must bring all of your medications and supplements with you to your appointment**. If previous hospital summaries or operative reports are available, we would appreciate you bringing them with you. This aids as a guide in the management of your care.

Prescriptions

For refills, please have your pharmacy fax a refill authorization to **(877)244-5666** one week prior to your completion of your dosing schedule. Prescriptions have a turnaround time of 24 to 48 hours.

If this is a new problem, you will need to schedule an appointment to be seen. We will need the prescription name and dosage, along with the pharmacy name and number. These will be called in as time permits. Check with the pharmacy before calling the office back. Prescriptions are legal documents and forgery or copying is a felony. Please keep them in a safe place.

Insurance/Billing

There are several insurance companies that we are contracted with and we will gladly file for you. You may have out of pocket expense for some of the plans that we are contracted with. YOU WILL BE RESPONSIBLE FOR ANY SUCH OUT OF POCKET EXPENSE TO INCLUDE DEDUCTIBLE, COPAY AND COINSURANCE AMOUNTS APPLIED BY YOUR INSURANCE PLAN.

Payment for routine office visits is expected at the time services are rendered. We can provide a copy of the receipt to file with your insurance company.

Fees and Payments

Payment/co-pay is expected at the time of your appointment. For cash pay patients we do offer a discount if payment is received the day of the visit.

Healow Pay Notifications for Balances & Statements

Our office uses **Healow Pay** to send reminders about balances and statements. These notifications can be sent via **text message** and **email** for your convenience. Please ensure we have your **preferred mobile number _____and email address** _____ on file to receive these updates. If you need to update your contact information, let our staff know.

A fee of $20.00 will be required for a form package to be filled out by a provider, which will be payable at time of drop off. Any sections that need to be filled out by the patient must be done prior to drop off.

Items you need to bring with you to your appointment:

- ( ) **Your medications**
- ( ) **Prior medical records and/or hospital reports**
- ( ) **Insurance cards and driver license or picture ID**

I have read and understand the requests mentioned above: _____

We are honored by your consideration of our practice, offering healthcare of high quality and value. We also consider the referral of your friends and family to our practice as the highest compliment and pledge our best efforts to serve their needs and yours. Thank you and we look forward to seeing you.

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Demographic Information

PLEASE ANSWER ALL INFORMATION OR PLACE NONE WHEN NEEDED

□ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Rev **First Name:** _____
Middle Initial:_____
Last Name, Suffix: _____

D.OB: _____ □ **Male** □ **Female** **Social Security Number:** _____

Marital Status: □ Single □ Married □ Divorced □ Widow(er) □ other: _____

Address: _____
STREET **CITY** **STATE** **ZIP**

Mailing Address: _____

Phone: (H) _____ (W) _____ (C) _____

Messages can be left on phone: □ Home □Cell □Work □ Email

Email: _____

Emergency Contact name: _____ **Phone:** _____

Race (per census bureau categorization):
□American Indian □Asian □Black or African American □Black Hispanic or Latino □Native Hawaiian or Other Pacific Islander □White □White Hispanic or Latino □ Unknown

How did you find us: □ Referred □ Friend □ Family □ Phonebook □ Website □ Other: _____

Employer/School Name or Retired/Disabled: _____

Spouse's name: _____ **Phone:** _____

Spouse's DOB: _____ **Spouse's Place of employment:** _____

Preferred Pharmacy: _____
NAME **CITY** **PHONE**

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Primary Insurance Plan Name: _____

Insurance ID Number: _____ **Group Number**:_____

Guarantor's Name: _____ **D.O.B**:_____

Relationship to Guarantor: _____

Secondary Insurance Plan Name: _____

Insurance ID Number: _____ **Group Number**:_____

Guarantor's Name: _____ **D.O.B**:_____

Relationship to Guarantor: _____

Please list all doctors you are currently seeing. It is important that you give us their First and Last Name, Phone Number, and City/State. Thank you for your help!

Primary Doctor: _____
NAME **CITY/STATE** **PHONE**

Referring Doctor: _____
NAME **CITY/STATE** **PHONE**

Seen for _____: _____
NAME **CITY/STATE** **PHONE**

Seen for _____: _____
NAME **CITY/STATE** **PHONE**

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Consent form / Assignment of Benefits / Information Release

I voluntarily consent to all healthcare services ordered on my behalf and/or provided to me by Nephrology of the Golden Isles through its physician(s) or any physician extender such as a advanced practitioner. The health care services may include, without limitation, routine physical and mental assessment, diagnostic (such as x-rays, imagining studies) and laboratory tests and monitoring, examinations, prescriptions for and/or administration of medication, procedures, treatment, and/or referral to a chronic disease management program sponsored by Nephrology of the Golden Isles.

I specifically consent, as applicable, to examinations, treatments, procedures, and blood tests ordered by my physician or advanced practitioner which may include blood tests for diseases such as HIV AIDS and/or hepatitis. I authorize the release of any medical information including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information necessary to process insurance claims, my treatment or for limited operational functions such as utilization review or quality assurance activities.

I knowingly consent to treatment by Nephrology of the Golden Isles and its physicians and advanced practitioners with the understanding that there are hazards and risks connected with all forms of treatment.

I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time. Nephrology of the Golden Isles may also change its services or update this form and ask me to complete a new consent form.

I assign all health insurance benefits available to me, whether primary, secondary, or tertiary, to Nephrology of the Golden Isles and its physicians or advanced practitioners. This assignment will remain in effect until revoked by me in writing. I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Nephrology of the Golden Isles. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, deductibles, and co-insurance except where my liability is limited by contract or state or federal law. A photocopy of this authorization shall be considered as effective and valid as the original.

I have read the above information and been given an opportunity to ask any questions that I may have. I realize that although every reasonable effort will be made to keep risks, side effects, and harm to a minimum that complications may be unpredictable both in nature and severity.

I understand that a physician as well as advanced practitioner may be involved in rendering my care and treatment. I understand that I may be additionally asked to sign a separate informed consent form for certain treatments or services that require additional consent. I also understand that I may obtain further information regarding the health services offered by Nephrology of the Golden Isles by contacting the office at (912)262-2723. With my complete understanding of the foregoing, I hereby voluntarily give my consent to treatment at Nephrology of the Golden Isles.

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I consent for a photograph to be taken of me. I understand that the information will only be used for identification purposes and will be stored securely. Refusal to photograph will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the practice.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

Name and Relationship of Legally Responsible Guardian (Print)

Name/Relationship: _____

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Welcome to CONNECTED CARE

To get started, please read and complete the enrollment form below

Connected Care is a service for patients diagnosed with chronic conditions like arthritis, diabetes, heart disease, or high blood pressure. Our dedicated care team will provide you with the best possible care between visits by partnering with you to proactively manage your health and help achieve your health goals!

Connected Care gives you on demand access to care when you want it.

No more phone tag. Text us anytime.

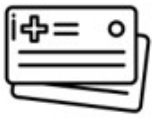
Not feeling well? Need a refill? Have a question? Simply text us at your convenience. Handle all the little things faster without waiting for a call back or scheduling a visit so you can spend more time doing what you love.

A personal health care assistant. Text your care team for help with:

- Scheduling appointments, follow-ups, and sick visits
- Questions about your health, medication, and symptoms
- requests for refills, referrals, lab results, and more

Your very own health coach. A dedicated care advocate to help with:

- Personalized care plan to help you achieve your health goals
- Weekly health reminders, tips, and assistance via text
- Monthly Care plan review to keep you on track



No out-of-pocket cost for most patients.

Insurance cost sharing applies, but most patients with dual coverage are not responsible for cost sharing. In addition, this service helps patients avoid more costly services by proactively managing health and preventing more expensive complications.

We look forward to partnering with you to achieve your health goals!

As part of my enrollment in connected care, I agree and consent to the following:

Connected Care - Chronic Care Management (CCM) Services

As a patient of Nephrology of the Golden Isles (“Healthcare Provider”) with chronic conditions, your healthcare provider recommends that you enroll in a CCM program

I agree to receive CCM services.

Most insurances will allow your healthcare provider to bill for these services during any month that they have provided eligible CCM services. Your provider is conducting this program in part by using Phamily an electronic patient communication platform that helps them more easily manage your care.

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I am not receiving CCM services from another provider at this time.
I acknowledge that only one practitioner can furnish CCM services to me during any 30 day period.

I have the right to stop CCM services at any time.
I may discontinue CCM services by revoking this agreement, verbally or in writing, effective at the end of the then current calendar month.

I may be responsible for co-pays if relevant and not covered by secondary insurance.
I permit my healthcare provider to bill my insurance provider for monthly CCM on my behalf. I acknowledge that standard insurance cost sharing could apply if relevant and my secondary insurance does not cover that cost.

Phamily - Patient Communication Platform
Phamily is a text, mobile, and web-based messaging platform that helps connect healthcare providers, patients, and their loved ones. Your healthcare provider has chosen to use Phamily to get updates on your health, send you reminders, answer questions, and improve access to your healthcare provider.

I agree to the Phamily Terms of Use.
I represent that I am 18 years of age or older and I acknowledge that I have read and agree to be bound by the Phamily End User Terms of Use as may be updated from time to time.

I agree to communicating over plain unencrypted text messages and/or e-mail.
I hereby authorize nephrology of the golden Isles and its affiliated medical professionals or staff members that it has designated to access and use the Family Services on its behalf, to communicate with me, and many permitted caregivers, about my medical conditions and treatment using unencrypted text messages and/or unencrypted e-mail including outreach that could be considered marketing messages.

I will only use family for routine and non-urgent needs.
Understand that the family service should only be used for routine and non urgent matters.

If you are experiencing a medical emergency or life-threatening symptom, please go to a hospital or contact 911 or your local emergency medical Services Agency.

I understand and agree to participate in the Connected Care CCM service powered by Phamily:

Name of Patient (please print): _____

Signature of Patient: _____

Date of Birth: _____

Date Signed: _____

Cell Phone Number: _____

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Authorized Caregivers (optional):

I agree that the individuals listed below, if any, shall each be a caregiver as defined in the Phamily End User Terms of Use.

Name of Caregiver (please print): _____

Relationship to Patient: _____

Caregiver Phone Number: _____

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PAYMENT POLICY

This office is committed to providing patients with the best possible care. In order to achieve this, we need your assistance and understanding of our payment policy.

AS A COURTESY, our office will bill most insurance companies.

HOWEVER, THE PATIENT IS RESPONSIBLE FOR ANY OUT-OF-POCKET EXPENSE TO INCLUDE DEDUCTIBLE, COPAY, CO-INSURANCE AMOUNTS, NON-COVERED CHARGES OR UNPAID BALANCES.

Your insurance coverage is a contract between you and your insurance company. All services will be filed with your insurance carrier providing you furnish all pertinent information to our office. Insurance co-pays are expected to be paid at the time services are rendered. We accept CASH, CHECK, CREDIT CARD, and DEBIT CARD. If you cannot make payment in full at the time of visit, you will be expected to participate in a payment plan program if applicable. We cannot accept sole responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not a party to your insurance contract.

I have read the above Payment Policy and understand that even with insurance coverage, IF CHARGES ARE DENIED I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED. If I need to set up an extended payment arrangement, I will contact the office immediately. If no payment has been received from either me or my insurance company after 90 days from the date of service, necessary collection procedures may begin.

Patient/Guardian Signature **Date**

Printed Name

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Medication Agreement & Refill policy

As part of your treatment, I may prescribe medication for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us and we need your help to make sure your treatment follows our guidelines. **If Nephrology of the Golden Isles has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies. I understand that if narcotic pain medicine is being provided to me to manage my pain, I am responsible for and agree to the following:**

1. I agree to follow the dosing schedule prescribed to me by my doctor. If I take more medicine than my doctor prescribed, I understand that it could make my condition worse.

2. I agree to **never** share my medications with others, nor will I sell or exchange my medication for any reason. I understand that it is against the law to change or forge a prescription. If any of these happen, my doctor will stop providing me with pain medicine and will result in immediate dismissal from Nephrology of the Golden Isles.

3. I agree to always keep my medications safeguarded and within my control, and that I must treat my medications as I would my money or valuable possessions. I understand that my pain medicine will not be replaced if it is lost or stolen. I understand that I am solely responsible for the safekeeping of my medications. It will not be replaced if I use them up too soon.

4. I agree to notify Nephrology of the Golden Isles if I experience any adverse effects or dosage problems with my prescribed medications. I will not discard any unused medications before any new medication can be prescribed. You may be asked to bring any unused medications to Nephrology of the Golden Isles for disposal.

5. I agree that if I receive narcotic prescriptions from Nephrology of the Golden Isles, I am **not** allowed to receive the same type of medications from other physicians without express consent or consultation with Nephrology of the Golden Isles. Only one doctor will prescribe narcotics for my pain.

6. I agree to use only one pharmacy for my pain-related medication unless extenuating circumstances prevent this from being possible. In this event, I will notify Nephrology of the Golden Isles of all pertinent information pertaining to additional pharmacies, mail-order, or other sources.

7. I understand that medication refill prescriptions involving narcotic pain medicine requires a **SCHEDULED** office visit when the doctor is on duty in the office. **Narcotic pain medication refills will not be called into a pharmacy, nor will they be increased over the telephone. I understand that medication refills cannot be made AFTER HOURS, ON WEEKENDS /HOLIDAYS or when the DOCTOR IS OUT OF TOWN. Our physician on call will NOT prescribe narcotics for any reason.**

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8. **I agree to keep all scheduled appointments and I understand that no medication will be given for cancelled or no-show appointments.** I understand that if I am more than 15 minutes late to my appointment time, I will have to reschedule – unless I have spoken to someone in the office.
9. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
10. I understand that abusive behavior or harassment toward any Nephrology of the Golden Isles staff will **NOT** be tolerated. I understand that I cannot present to Nephrology of the Golden Isles unannounced seeking medication refills.
11. If I have a new injury or pain problem, I might need a new prescription. If this happens, I will call or make an appointment with my doctor to find out if my dose needs to be changed.
12. My doctor may refer me to other doctors to help manage my pain. I agree to have urine and/or blood test by my doctor or another doctor to check on the levels of medicine in my body. If other controlled substances show up in a test, my doctor will stop my pain prescription. Examples of other substances are cocaine, marijuana and street drugs. Also, if any prescribed medicines do not show up in the urine test, my doctor will stop my pain prescription.

I understand that I may be dismissed from Nephrology of the Golden Isles if I do not abide by the terms of this medication agreement. By signing the agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. NO medication will be prescribed without acceptance of this agreement.

Signature: _____

Date: _____

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Pharmacy Name: _____ Pharmacy Number:_____
Patient Name: _____ DOB: _____ Age: _____ Date: _____
Primary reason for today's visit? _____

PLEASE CHECK ALL SYMPTOMS THAT APPLY

Symptom/Problem	Check all that apply(SELF)	FAMILY HISTORY (Blood Relations Only)
Kidney Disease		Yes ___No___ Who?
Diabetes Type 1 ___ Type 2 ___ Taking Insulin?		Yes ___No___ Who?
High Blood Pressure		Yes ___No___ Who?
Ischemic heart disease		Yes ___No___ Who?
Cancer (type_____)		Yes ___No___ Who?
Stroke or TIA/mini-stroke		Yes ___No___ Who?
Gout		Yes ___No___ Who?
ADPKD		Yes ___No___ Who?
Dementia		Yes ___No___ Who?
Blindness		
Cataracts		
Hearing Problems		
Glaucoma		
Atrial fibrillation		
Pacemaker		
High Cholesterol		Yes ___No___ Who?
AICD		
Valvular heart disease		Yes ___No___ Who?
Congestive heart failure		Yes ___No___ Who?
Mitral valve prolapse		
COPD/Emphysema/Bronchitis		
Asthma		
Tuberculosis		Yes ___No___ Who?
Sleep Apnea		
Heartburn/Gerd		
Stomach/Bowel ulcers		
Hepatitis		
Irritable Bowel Syndrome		
Gluten intolerance		
Symptom/Problem	**Check all that apply(SELF)**	**FAMILY HISTORY (Blood Relations Only)**

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Kidney Stones		
Frequent UTIs		
Osteoarthritis		
Osteoporosis/Osteopenia		Yes ___No___ Who?
Multiple sclerosis		
Seizures		
Parkinson's		
Depression		
Anxiety disorder		
Muscle Pain/Fibromyalgia		
Thyroid Problems		
Anemia		
Sickle cell disease		
HIV		
AIDS		
Rheumatoid arthritis		
Lupus		

Surgical History

Type of Procedure	Procedure Date or Age When Performed

Allergies

To	Reaction

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Social History

Marital Status: (Circle one) Single Married Divorced Widow(er)

Occupation: _____ Current Employer: _____

How much caffeine (coffee, tea, soda, etc.) do you drink? _____# Servings per (circle one) day week

How much alcohol do you drink? _____# Servings per (circle one) day week

Do you use tobacco? Yes_____ No_____ If yes: Current or Former

(circle all that apply) Cigarettes Cigars Chewing tobacco snuff/dip

How long have you (or did you) smoke? _____Years # of packs per day _____ Quit year _____

Do you now or have you ever used: Yes_____ No _____ If yes: Current or Former

(circle all that apply) marijuana cocaine other street drugs _____

Would you like information related to: (circle all that apply)
Domestic abuse Elder Abuse other _____

Medical Advance Directive

A **Medical Advance Directive** is a legal document that outlines your healthcare preferences in case you become unable to make decisions for yourself. It may include a **Living Will**, which specifies the types of medical treatments you do or do not want, and a **Healthcare Proxy** (or Durable Power of Attorney for Healthcare), which designates someone to make medical decisions on your behalf.

Having an **Advance Directive** ensures that your wishes are respected and helps guide your loved ones and healthcare team in making critical decisions.

Do you have an Advance Directive?

☐ Yes ☐ No ☐ I choose not to answer this question

If Yes, are you: ☐ Full Code ☐ DNR

☐ Other – please explain_____

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Notice of Privacy Practices

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We also required by Federal law to maintain the confidentiality of your health information. Although these laws are complicated, all medical providers are required to provide you with this important information.

The HIPAA law permits the use and disclosure of personally identifiable health information as needed for diagnosis, treatment, or billing of health care services, provided that any such disclosure must be limited to the minimum necessary information to accomplish these purposes, and only to properly qualified persons. Special safeguards must be maintained to minimize any chance of inadvertent disclosure of personally identifiable health information to unauthorized person, particularly of especially sensitive information such as psychological or HIV status. We are committed to maintaining the security and privacy of all information (including billing information) contained in my medical records, including electronic records and data transmission.

Use and disclosure of your health information in certain circumstances:

The following additional circumstances may also require us to disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect such information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety or another individual or the public. I will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or Foreign Military Forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.
9. In order to advert a serious threat to the health and safety of you or any other person pursuant to applicable law.

Patient/Guardian Signature **Date**

Printed Name

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Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in my use of disclosure of your health information treatment, payment, or health care operations. Additionally, you have the right to request that I restrict my disclosure of your health information to only certain individuals involved in your care of payment for your care, such as family members and friends as provided by 45CFR § 164.522. I am not required to agree to your request; however, if I do agree, I am bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes as outlined in 45CFR § 164.524. You must submit your request in writing to the office of Nephrology of the Golden Isles.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for my practice as provided for in 45CFR § 164.526. To request an amendment, your request must be made in writing and submitted to Nephrology of the Golden Isles. You must provide a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice, contact the receptionist.
6. Accounting (list) of disclosures. You have a right to receive an accounting of all applicable disclosures made of your health information as provided by 45CFR § 164.526.
7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with my practice or with the secretary of the U.S. Department of Health and Human Services. To file a complaint with our office, contact the practice manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. My practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
9. If you have any questions regarding this notice or my health information privacy policies, please contact the practice manager at Nephrology of the Golden Isles.

I AGREE FOR THE FOLLOWING PERSON(S) TO HAVE PERMISSION TO HAVE ACCESS TO MY MEDICAL RECORDS AND COMMUNICATE WITH MY PROVIDER(S) REGARDING MY HEALTH CARE. THIS MAY BE CHANGED BY COMPLETING A NEW FORM.

AUTHORIZED PERSON(S):

1.) _____

2.) _____

3.) _____

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices.

Printed Name of patient: _____
Signature of patient/guardian: _____
Date Signed: _____

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Medical Release Form

_____AUTHORIZATION FOR RELEASE OF INFORMATION

_____AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize Nephrology of the Golden Isles to obtain/disclose information from the medical records of:

PATIENT NAME: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

OBTAIN FROM/DISCLOSE TO: _____

PHONE: _____ FAX : _____

The following Information to be obtained/disclosed (Extent or nature of information with inclusive dates)

_____

Purpose or need for information: _____

This authorization is valid for one year and can be revoked, in writing, but not retroactive to the release/disclosure of information made in good faith.

DATE: _____ SIGNATURE:_____

RELATIONSHIP:_____

DATE: _____ WITNESS: _____

NEPHROLOGY OF THE GOLDEN ISLES

3025 Shrine Rd, Suite 270 Brunswick, GA 31520
Phone : (912)262-2723 Fax: (877)244-5666

MEDICATION LIST

Patient Name: _____**DOB**: _____ **Age**: _____ **Date**: _____

Name of Medication	Dosage	How Often (i.e 2x per day)