Nephrology Associates
Privacy Practices

Patient Name: ______________________________ Date: ____________________

Privacy Notice - We are required to provide you with a copy of our Notice of Privacy Practices to review, which states how we may use/disclose your health information.

(Please initial)

____ **I acknowledge that I have received a copy or been given the opportunity to review the Notice of Privacy Practices for Nephrology Associates. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.**

---

ePrescribing - is defined as a physician's ability to electronically send an accurate and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have been included in an ePrescribe program. These include:

- Formulary and Benefit Transactions – provides prescriber information about what is covered by health plan
- Medication History Transactions – provides prescriber with medications patient is currently taking to minimize adverse effects
- Fill Status Notifications – provides provider with status of refill (picked up, not picked up, partially picked up)

____ **I agree that Nephrology Associates can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.**

____ **I provide informed consent to Nephrology Associates to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.**

HIPAA - You may revoke this consent to the use and disclosure of your protected health information at any time in writing. Any use or discloser prior to date of your revocation will not be affected.

I give my permission to Nephrology Associates to discuss and/or release my protected health information to:

____ **My primary care physician and specialists (listed on my Patient Information form)**

____ **These family members or friends:**

Name: ____________________________ Phone: ____________________
Address: ____________________________ Relationship: ____________________

Name: ____________________________ Phone: ____________________
Address: ____________________________ Relationship: ____________________

Patient Signature: ____________________________ Date: ______________