NORTHWEST Kidney Centers

INSTRUCTIONS: Patient Authorization to Release Medical Information

Medical information (PHI) generally refers to demographic information, medical history, test and laboratory results, insurance information and other information that a healthcare professional collects to identify an individual for the purposes of health care treatment, payment or operations.

PHI may include:

- Your name;
- Social Security number;
- Driver's license or State identification numbers;
- Telephone numbers;
- Personal email address or home addresses;
- Medical record numbers or prescription numbers;
- An X-ray, MRI or CT scan; and
- Blood test or other lab test results.

This form is used to authorize the release of a patient's PHI. All fields labeled "Required" must be completed. This form may be considered invalid if information is left blank.

The "MY Information" Section: This information identifies the person whose information is to be released.

Required information in this section includes your full name, date of birth, street address, city, State, zip code.

The "Share My PHI" Section: This section provides Northwest Kidney Centers with information about who you want us to share your PHI with. This information can be a specific person or an organization.

Required information: The name of the person or organization, phone number, street address, city, state, and zip code.

Optional information: Email address and the identification number assigned to you by the person or organization (if any) that you want Northwest Kidney Centers to share your information.

The "Northwest Kidney Centers Can ONLY Share the Records Chosen Below" Section: This section identifies what type of information you are authorizing Northwest Kidney Centers to share and the time dates of service. The authorization can be revoked at any time except for information that has already been shared. You will get a copy of the authorization after you sign it.

Your treatment with Northwest Kidney Centers will not be impacted if you choose not to share your information. The information shared by Northwest Kidney Centers may be shared again by the person or organization to whom the information is shared, and the information may not continue to be protected under federal and state law.

Check the boxes and initial in the sections that tell us what information you want us to share. Checkboxes and initials are required.

The authorization to share your PHI is limited to a date you tell us or for up to one year if you don't specify a date.

If you are asking Northwest Kidney Centers to let you see medical record information for an individual for whom you are the Parent, Legal Guardian, Health Care Agent, or Authorized Representative, you must check what your authority is to access the individual's information. You must provide legal documentation of your authority to act on the individual's behalf. You must sign and date the request.

For questions about this form contact the Health Information Management Department at 206-901-8711.

NORTHWEST Kidney Centers

Patient Authorization to Release Medical Information

NKC Patient MRN	

FOR NORTHWEST KIDNEY CENTERS USE ONLY

My Information (Required)

First Name	M. I.	Last Name	Date of Birth

I request that Northwest Kidney Centers SHARE MY PHI with the Person or Organization Below:

Person or Organization Name (Required)		Phone (Required)
Street Address (Required)		**City (Required)**
State (Required)	**Zip Code (Required)**	**Fax Address**
Organization Identifier (Member # or Patient Account #) **DO NOT USE SOCIAL SECURITY NUMBER**		

Northwest Kidney Centers Can ONLY Share the Records Chosen Below:

☐ _____ (Initial) I authorize the release of **all medical records** related to my care at Northwest Kidney Centers, including sensitive information about my health conditions which may include records of sexually transmitted disease, HIV/AIDS status, alcohol and drug use, and behavioral or mental health conditions.

☐_____ (Initial) I authorize the release of **medical records <u>EXCLUDING</u> the following sensitive information:**

☐ Sexually Transmitted Disease ☐ HIV/AIDS status ☐ Alcohol and drug use

☐ Behavioral/Mental Health ☐ Genetic Information ☐ Other

Describe Other: _____

I request that the release of medical records indicated above be restricted to the following dates of service:

From _____ To _____

☐ I understand this authorization may be revoked at any time except to the extent that identified information has already been released. A request to revoke this authorization must be made in writing to Northwest Kidney Centers.

☐ I understand that I will receive a copy of this authorization after I have signed it.

☐ I understand Northwest Kidney Centers will not condition treatment on whether I sign the authorization.

☐ I understand the 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.

Effective: 03/21/18 MR-C16015

NORTHWEST Kidney Centers

Patient Authorization to Release Medical Information

Patient MRN	FOR NORTHWEST KIDNEY CENTERS USE ONLY	Patient Name

This authorization is in effect until: _____ (date). If no date is indicated, this authorization will expire one year from the date it is signed.

Patient Signature (Required)	Date (Required)

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized representative may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

  ☐ Legal Guardian ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless the patient is an emancipated minor under WA State law.

Please indicate your relationship: ☐ Parent ☐ Legal Guardian ☐ Authorized Representative

Parent/Guardian/Representative Signature (Required)	Date (Required)

Printed Name of Person Signing (Required)

Mailing Address (Street address or P.O. Box Number)

City	State	Zip Code	Phone Number

Return this form to: Northwest Kidney Centers

17900 International Blvd., STE 405, SeaTac, WA 98188 | Phone: 206-901-8711 | Fax: 206-901-8725

☐ I understand this authorization may be revoked by me in writing at any time.

☐ I hereby revoke this authorization.

Patient Signature (Required)	Date (Required)

NOTICE TO RECIPEINT(S) OF THIS INFORMATION ABOVE: Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains to or as permitted by such laws. A general authorization is NOT sufficient consent for the release of these types of information.