NORTHWEST Kidney Centers

Authorization for a 3rd Party to Release Medical Information to Northwest Kidney Centers

The information marked with an asterisk " * " is required. **My Information**:

* First Name	M. I.	* Last Name	* Date of Birth

☐ I request that the Organization/Individual named below share MY Medical Information with Northwest Kidney Centers, ATTN: Medical Records, 17900 International Blvd., STE 405, SeaTac, WA 98188, Phone: 206-901-8711; Fax: 206-901-8725:

* Person or Organization Name, or Class of Persons		* Phone
* Street Address		* City
* State	* Zip Code	Fax Number or Email Address

I Authorize Sharing My Medical Record Information Chosen Below:

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

☐_____ (Initial) I authorize the release of **all medical records EXCLUDING the following sensitive information:**

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

☐ Behavioral/Mental Health ☐ Genetic Information ☐ Other

Describe Other: _____

The purpose of this disclosure is: _____

_____

I request the release of medical records indicated above for dates of service:

From _____(date). To _____(date).

☐ _____ (Initial) I understand I will receive a copy of this authorization after I have signed it. I understand I DO NOT have to sign this form to get care. I understand that this information may be redisclosed by the recipient listed above.

This authorization is valid until: _____ (date) or termination of treatment.

* Patient/Authorized Representative Signature	* Date

_____

If the signature is of an authorized representative describe their authority to act on behalf of the patient (Power of Attorney, Guardian, etc.).

This authorization may be canceled at any time by checking this box and signing and dating below. ☐ I hereby revoke this authorization.

* Patient Signature	* Date