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

The information marked with an asterisk " * " is required.

My Information:

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

☐ I request that Northwest Kidney Centers share MY Medical Information with:

* 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 for: ____

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 and may no longer be protected by law.

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

* Patient/Authorized Representative Signature	* Date

____

Describe the authority of the representative to act on behalf of the patient (POA, 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 Authorizing Cancellation	* Date

NOTICE TO RECIPEINT(S) OF THE PATIENT INFORMATION LISTED 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.