KSM
KIDNEY SPECIALISTS
OF MINNESOTA

Authorization to share Protected Health Information (PHI)

I, (patient, parent, legal guardian),_____(print name), hereby authorize Kidney Specialists of MN to share PHI verbally or in writing with:

Name_____

Relationship_____Phone Number_____

Regarding:

Patient Name_____Date of Birth _____

Kidney Specialists of MN will not share any protected health information other than what is indicated below unless initialed to do so.

State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information shared. If not indicated, information will not be shared, released, or obtained.

_____X-ray Films/ Reports _____History & Physical Exam
_____Laboratory Results _____Others:

Unless otherwise revoked, this authorization will expire five years from the date it is signed

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Kidney Specialists of MN.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Patient/Guardian Signature Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)