KSM
KIDNEY SPECIALISTS
OF MINNESOTA

AUTHORIZATION TO USE AND/OR DISCLOSE PATIENT INFORMATION

Patient Information	Name:_____ Date of Birth: ____/____/____ Address:_____ Day Phone: _____ City:_____ State:_____ Zip:_____
TO: (Who are records going to? Fill out completely and legibly)	Name:_____ Attn: Medical Records Address:_____ Day Phone:_____ City:_____ State:_____ Zip:_____ Fax Number (for patient care only):
FROM: (Where are the records coming from? Fill out completely and legibly.)	Name:_____ Attention: Medical Records Address:_____ Day Phone:_____ City:_____ State:_____ Zip:_____ Fax Number (for patient care only):
Information to be Released (What information and/or dates do you want released? Check appropriate box.)	Indicate Date(s) of Service for the records checked below:_____ or All Dates *(If left blank, we will release only the last years' records.)* ☐ **All Medical Records** ☐ Scans/Ultrasounds ☐ Speech Therapy Notes ☐ Dictations ☐ Occupational Therapy Notes ☐ Most Recent History and Physical ☐ Psychotherapy Notes ☐ Progress Notes ☐ Lab Reports ☐ Operative Reports ☐ Audilogy ☐ Consultation ☐ Sleep Center Results ☐ Xray Reports ☐ Pathology Reports ☐ Other_____
Instructions for Release (How and when is the information needed?)	Date Information Due:_____ (please allow 7 days for completion) ☐ Paper ☐ Fax (patient care only)
Purpose of Release (Why is the information needed?)	☐ Continuing Care ☐ Seeing Another Provider ☐ Insurance Claim/Payment ☐ Insurance Application ☐ Personal Use * ☐ Litigation/Legal * ☐ Other * * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R§164.524

- This authorization lasts for one year after the date of signature unless you enter a different date of expiration: _____
- This authorization may be canceled in writing at any time
- KSM will not restrict treatment if you choose not to sign this authorization.
- A copy of this authorization will be treated in the same way as the original.
- KSM cannot prevent re-disclosure of your information by the entity who receives your records under this authorization and your information may no longer be protected by the Federal HIPAA Privacy Rule after release.
- Your signature indicates that you have read and understand this form and authorizes the release of your information as indicated above.

_____ Patient /Parent/ Legal Guardian Signature

_____ Date

_____ Authority to act on behalf of patient (attach document)