HIPAA CONSENT FOR RELEASE OF MEDICAL INFORMATION
HIPAA CONSENT FOR TO ACCESS HISTORY SCRIPTS

Dear Patient,

In order to protect your confidentiality and to comply with government regulations (HIPAA), Kidney Associates of Kansas City, PC (KAKC) is required to obtain authorization from you in order to leave messages and /or provide information regarding your care with any persons(s) other than yourself.

RELEASE OF MEDICAL INFORMATION:
The physicians and staff at KAKC may discuss my medical information and/or care to the following:

☐ My spouse, (Name) ____

Name ____ Relationship ______________________

Name ____ Relationship ______________________

Name ____ Relationship ______________________

MESSAGES:
I give my consent to the physicians and staff of KAKC to leave messages or discuss scheduling, treatment, surgery, lab, radiology results or other information regarding my care as follows:

On answering machine or voice mail at home /or cell phone YES OR NO (circle one)
On answering machine or voice mail at work YES OR NO (circle one)

☐ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.

<u>HIPAA CONSENT</u>:
I have received Kidney Associates of Kansas City notice of privacy practices. This is the form titled HIPPA Notice of Privacy Practices (**Please Initial): ____________**

<u>HIPAA CONSENT SCRIPTS</u>:
I give my consent by authorizing Kidney Associates to access my prescriptions **<u>history</u>** from the electronic system, Sure Scripts. **(Please initial)** _____________________

Patient's Name (please print) ____

Date: ___________

Patient's Signature ____