NORTHWEST NEPHROLOGY CLINIC

HYPERTENSION AND NEPHROLOGY

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HIPAA ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO DISCLOSE PHI

Date: _____

I, the undersigned acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for Northwest Nephrology Clinic, PC ("Group").

I hereby consent to the disclosure of information from and/or copies of all my medical records by Group, its staff and business associates (as that term defined under the Health Insurance Portability and Accountability Act of 1996, as amended) to any person, corporation, governmental agency or other entity performing services related to my treatment, billing and/or obtaining payment for my care, or for group's healthcare operations or otherwise in accordance with the Group's Notice of Privacy Practices. I also consent to the disclosure of my health information to the individuals listed below who are involved in my health care.

PLEASE LIST ANY PARTIES INVOLVED IN YOUR HEALTH CARE OR PAYMENT FOR YOUR CARE TO WHOM WE MAY DISCLOSE YOUR HEALTHCARE INFORMATION RELATED TO THEIR PARTICIPATION IN YOUR CASE. (This includes family members such as your spouse, children, grandchildren, sister, brother, and my care takers who can have access to your records.)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

__ If checked, this consent specifically allows the release of any information from or copies of my medical record concerning treatment for mental illnesses and psychiatric conditions, for drug or alcohol abuse, drug-related condition, alcoholism, as applicable.

I also consent to (a) the release of all or part of my medical record to Group for treatment purposes by any and all physicians, hospitals, and other health care providers; and (b) the release to Group of information from and/or copies of payment records pertaining to the medical services provided by group by any persons, corporation, or other entities that are legally responsible for the payment (all or in part) of the medical services provided to me.

I understand that I may revoke all or part of this consent at any time in writing, but if I do so it may adversely affect Group's ability to treat me appropriately or even to continue to provide my care. I hereby waive any requirement that this consent be addressed to any specific person or institution or dated within any particular time period before a disclosure of my medical records is made.

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- Cell phone confirmation
- Home phone confirmation
- Work phone confirmation
- Email confirmation
- U.S. Mail/Postcard
- Fax
- Any of the above

I AUTHORIZE INFORMATION ABOUT MY HEALTHCARE TO BE CONVEYED VIA:

- Message on cell phone
- Message on home phone
- Message on work phone
- Email message
- U.S. Mail/Postcard
- Fax
- Any of the above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, OR NEW HEALTHCARE INFO VIA:

- Phone Message
- Email
- U.S. Mail/Postcard
- Any of the above

A photocopy of this consent shall have the same force and effect as the original

I have read the above acknowledgement and consent and I understand nature and purpose of this acknowledgement and consent.

_____ _____

Patient Name Please sign your name

_____ _____

Legal Representative Description of Authority