ADVANCED KIDNEY CARE OF CENTRAL FLORIDA

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131 Webb Dr, Suite C Davenport, FL 33837 PH: (863) 226-4676 | FAX: (888) 716-2003

CONSENT TO DISCLOSE MEDICAL INFORMATION

PREFERRED FORM OF COMMUNICATION

It may be necessary to communicate with you regarding a change in your appointment, instructions, and other information regarding your treatment. In the event we are unable to reach you personally, please give us instructions regarding the best way to communicate with you.

I authorize the staff at Advanced Kidney Care of Central FL, PA to contact me by any of the following methods to relay a message:

[ ] Yes [ ] No Home telephone: (_____)
[ ] Yes [ ] No On answering machine
[ ] Yes [ ] No With anyone answering the phone
[ ] Yes [ ] No Authorized persons only: _____ Relationship _____
_____ Relationship _____
_____ Relationship _____
[ ] Yes [ ] No Leave message with call-back number only

[ ] Yes [ ] No Work telephone: (_____)
[ ] Yes [ ] No On answering machine
[ ] Yes [ ] No With anyone answering the phone
[ ] Yes [ ] No Leave message with call-back number only

[ ] Yes [ ] No Cell phone: (_____)
[ ] Yes [ ] No On voicemail
[ ] Yes [ ] No With anyone answering the phone
[ ] Yes [ ] No Leave message with call-back number only

RELEASE OF MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

If you would like to share your medical information with another person, please specify their name(s), phone number, and their relationship to you. If you do not designate someone, we cannot discuss your medical condition or laboratory/test results with anyone other than yourself (HIPAA Regulation).

Their Name	Their Phone #	Relationship
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I hereby release, discharge and agree to hold harmless all parties whom the consent is given from any liability that may arise from the release of information to those authorized above. I realize that I may revoke this consent in writing in the future.

I have received and understand the Notice of Privacy Practices.

_____ _____
Patient/Guardian Signature Date