KSM

KIDNEY SPECIALISTS OF MINNESOTA

CONTACT PERMISSION FORM

Patient Name: ______________________________ Date of Birth: ________/_______/_______

Notify in case of an emergency (other than spouse/and not living at patient's address):

Name ____ Phone ______________________________

Relationship _________________________

While under the care of Kidney Specialists of Minnesota, P.A. (KSM), I hereby give authorization for the release of private health related information to the following persons (e.g., physicians and/or relatives):

NAME	RELATIONSHIP TO PATIENT	PRIMARY PHONE NUMBER

Non-English-speaking patients, please identify at least one (1) English-speaking contact:

NAME	RELATIONSHIP TO PATIENT	PRIMARY PHONE NUMBER

I hereby give authorization for the release of private health related information to the following persons via the Patient Portal:

NAME	RELATIONSHIP TO PATIENT	PRIMARY PHONE NUMBER

This information may be given to the above mentioned people either by phone, fax machine, Patient Portal, or in person should the need arise for this information to be released for my proper care while a patient here. Should any unforeseen incident arise that I wish not to inform any or all of the above named persons, I will notify KSM in writing of such changes.

I authorize KSM and staff to leave voicemail messages regarding medical information pertaining to my care using the following methods, and will assume responsibility to notify KSM and staff whenever this information changes:

	YES	NO*	NA
Primary Phone			
Secondary Phone			
Work Phone			
Patient Portal			

*This does not apply to appointment reminder calls made the day before your appointment unless noted here: ___________________________

DATE: ________________________**SIGNED:** X ____