KIDNEY SPECIALISTS
OF MINNESOTA

Authorization to Share Protected Health Information (PHI)

I, (patient, parent, legal guardian), _____ (print name), hereby authorize Kidney Specialists of Minnesota, P.A. (KSM) to share PHI verbally with the following individual(s):

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

☐ I decline to complete this form

Unless otherwise revoked, this authorization will expire five years from the date it is signed.

By signing or giving verbal consent this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Kidney Specialists of MN.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature (Patient/Legal Guardian)

_____

Relationship to Patient (if applicable)

_____

Date Signed

_____

Patient Name:
Date of Birth: