KIDNEY SPECIALISTS
OF MINNESOTA

# Patient Consent for Treatment and Release of Information

**PAYER & NETWORK RECORD RELEASE:** I hereby authorize Kidney Specialists of Minnesota, P.A. (KSM) to both obtain and release my medical records and billing information (Information), including protected health information, to Medicare, my insurance company, health plans, payer network organizations, accountable care organizations (ACOs), their contractors and third-party administrators, and all providers involved in my care (primary care, referring physicians, and others) for treatment, payment, and healthcare operations. I further authorize the assignment of medical benefits to KSM and request payment of authorized Medicare and MEDIGAP benefits be made to KSM for services rendered. I authorize the release of any necessary medical or hospital information to the Center for Medicare and Medicaid Services (CMS) or applicable MEDIGAP carriers to determine benefits payable, permitting a copy of this authorization to be used in place of the original.

**EMR RELEASES:** I hereby authorize KSM to share my Information obtained from KSM with healthcare providers other than KSM who utilize the same electronic medical record ("EMR") system subject to the requirements of and to the extent authorized under such EMR system.

**CONSENT TO TREATMENT:** I authorize KSM, its physicians, and any employee working under the direction of the physician or providers working with KSM to provide medical care to me. This medical care may include services and supplies related to my health and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling assessment of review of mental status/functions of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professions for care and treatment as well as a consent to communication and treatment through telemedicine.

**KSM DOCUMENTS:** I acknowledge receipt and review of, and agree to abide by, the following KSM documents. I understand that these documents are also available upon request or on our website at https://ksmclinics.com:

- Financial & Clinical Policy
- Notice of Privacy Practices

I give KSM authorization to leave a detailed voicemail on the following phone line. I understand this may include private health information including test results (please choose one):

☐ HOME ☐ CELL ☐ WORK ☐ NONE

Patient Name: _____

Date of Birth: _____

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## Patient Consent for Treatment and Release of Information

I permit a copy of the authorization to be used in place of the original. I agree that the authorizations and consents provided above shall be effective indefinitely unless terminated via written notice to:

Privacy Officer
Kidney Specialists of Minnesota
6200 Shingle Creek Pkwy, Suite 260
Brooklyn Center, MN 55430

I understand that terminating this authorization will not affect the information disclosures that occurred prior to the revocation of this consent.

A copy of this signed document will be viewable on your MyChart and can be printed upon request.

Signature (Patient/Legal Guardian)

_____

Relationship to Patient (if applicable)

_____

Date Signed

_____

Printed Name

_____

Patient Name:

Date of Birth: