Kidney Care Specialists, LLC
Valley Kidney
1230 South Cedar Crest Blvd., Suite 301• Allentown, PA 18103

PRIVACY RULE

This form allows you (the patient) to give Kidney Care Specialists, LLC authorization to disclose your protected health information (PHI) to your Personal Representative. The information covered by this authorization is protected health information, including identification of treating providers of care, diagnosis, procedures, and personal information, such as your date of birth and mailing address.

Each adult family member, including each adult child (age 18 or older or as determined by state law) who wishes to name a Personal Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. You are not required to name a Personal Representative, but if you do not, we will not release your protected health information to someone who may call or write on your behalf. Your Personal Representative may be anyone of your choosing, such as spouse, parent, child, friend, etc. You must provide the information requested for each person before we can treat that person as your representative.

Please note: This authorization does not give your Personal Representative authority, either implied or direct, regarding medical treatment, or direct medical care decisions.

I authorize Kidney Care Specialists, LLC to treat the person(s) named as my Personal Representative(s) subject to the restrictions named.

Patient Name: _____ Date of Birth: _____

Daytime Phone: _____

I understand that Kidney Care Specialists, LLC will not disclose my personal health information, except for the purpose of treatment, payments, and health care operations, or as requested by law, without my written authorization. For this reason, I authorize you to disclose my protected health information to the person(s) named for the purpose of assisting with or facilitating the payment of my health plan benefits. I understand my Personal Representative is not bound by federal or state privacy laws, and may disclose my protected health information without my authorization. I acknowledge that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a particular provider or diagnosis/disease. Any such limitations must be described in Restrictions.

PLEASE COMPLETE BOTH SIDES AND BRING TO YOUR APPOINTMENT

OVER ➔

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Personal Representative #1

Full Name: _____ Phone Number: _____

Relationship to You: _____

Restrictions: _____

_____

_____

_____

Personal Representative #2 (Optional)

Full Name: _____ Phone Number: _____

Relationship to You: _____

Restrictions: _____

_____

_____

_____

Personal Representative #3 (Optional)

Full Name: _____ Phone Number: _____

Relationship to You: _____

Restrictions: _____

_____

_____

_____

I understand that I do not have to name any person as my Personal Representative. I understand that I have the right to revoke or end this authorization at any time by giving written notice of my decision. I understand that my withdrawal of this authorization will not affect any action that Kidney Care Specialists, LLC has taken or information that Kidney Care Specialists, LLC has released, based upon your prior authorization.

I, _____, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that Kidney Care Specialists, LLC may disclose my protected health information to the person(s) named on this form, for the purpose described above.

Patient Signature: _____ Date: _____

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT