Oahu Kidney Care LLC

Patients Consent for Use and Disclosure of Protected Health Information
Health Insurance Portability & Accountability Act (HIPAA)

With my consent, the Doctors and his/her staff may use and disclose **Protected Health information (PHI)** about me to carry out **Treatment, Payment and Healthcare Operations(TPO).**

With my consent, the Doctor and his/her staff my call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, etc.

With my consent, the Doctor and his/her staff may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, the Doctor and his/her staff may speak and release my PHI to the following spouse, family member, relative, friend or parties listed below.

Name	Relationship	Name	Relationship

I understand that if my PHI is disclosed to a party who is not required to comply with the federal privacy protection policies, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

This consent covers the period of time from my first contact to my last contact with Oahu Kidney Care. I release the Doctor and staff from all legal responsibility that may arise from this authorization.

By signing this form, I am consenting to the Doctor and his/her staff use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian Date

Print Name of Patient Print Name of Legal Guardian