Oklahoma Kidney Care
Dr. Lorraine Wilson, Dr. Radhika Medipalli, Dr. Kaelin Merveldt, and Dr. Celeste Boeckman

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HIPAA Release Form

Patient Name: _____ **Date of Birth:** _____

The following individuals are permitted to obtain and/or discuss my healthcare outcome, diagnosis, treatment plan(s), verify, confirm, schedule/reschedule appointments and assist with billing questions or payments. I understand this release remains active until I submit a written request to terminate and/or make updates.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

In compliance with HIPAA Notice of Privacy Practices I authorize the release of any normal and/or abnormal test results in the following manner: (please check all that apply)

___Yes ___No - Permission to leave voicemail message

___Yes ___No - Permission to notify me in writing

___Yes ___No - Permission to speak with my spouse

___Yes ___No - Permission to speak with my parents

___Yes ___No - Permission to speak with my child/children

Other: _____

Patient Signature: _____ **Date:** _____

Release of information:

I hereby authorize the release of pertinent medical records from Oklahoma Kidney Care for insurance claim purposes and solely at the request of the insurance carrier.

I understand that Oklahoma Kidney Care works collaboratively with all providers involved in my care to ensure continuity of care for the benefit of my overall healthcare. I authorize Oklahoma Kidney Care to share and disclose all necessary healthcare related information with my primary care physician, consulting/referring physician and other health care provider(s) who have an active role in my healthcare. **The information released may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).**

Patient Signature: _____ **Date:** _____

Authorizations:

I understand that my insurance carrier will be billed for services rendered at Oklahoma Kidney Care and I authorize my insurance carrier to pay benefits directly to Oklahoma Kidney Care. I understand that I am financially responsible for all patient responsibility applied by my insurance carrier per my plan benefits to included but not limited to copay, coinsurance, deductible and/or denied services.

Consent to Treat

I consent to the services that may be performed by an Oklahoma Kidney Care physician or non-physician provider. I understand I can withdraw this consent at any time. This consent and agreement apply to any provider services I may obtain from Oklahoma Kidney Care.

My signature confirms I have received HIPAA privacy notice as well as my approval for authorization and consent to treat outlined above.

Patient Signature: _____ **Date:** _____