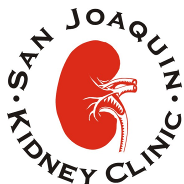



# San Joaquin Kidney Clinic, Inc.

1801 E. March Lane, Suite#B-265, Stockton, CA 95210, Phone (209) 546 1868, Fax (209) 461 6505
801 S. Ham Lane, Suite# J, Lodi, CA 95242, Phone (209) 369 7336
1530 Bessie Avenue, Suite 107, Tracy, CA 95376, Phone (209) 831 9923

## CONSENT

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.

You have the right to request that we restrict how we may use or disclose your protected health information to carry out treatment, payment activities and health care operations. We are *not* obligated to agree to these restrictions. If we elect to agree, we will be bound only by the restrictions to which we agree.

You may withhold signing this consent until you have our decision on your request for restrictions, or you may revoke this consent if we decline to agree with your request for restrictions. Please understand that we may decline to treat you until we have this consent, and we may decline to treat you or continue treating you if you revoke this consent.

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Office listed above. We may ask you to complete our Consent Revocation Form to ensure that we have accurate information regarding your decision to revoke this consent.

Please understand that revocation of this consent will *not* affect any action we took in reliance on this consent before we received your written notice of revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, ________________________ have had full opportunity to read and consider the contents of this consent form. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

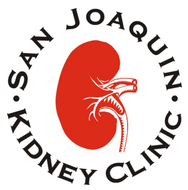
Signature: ________________________________________ Dated: ________________________

If this consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ____________________________________________________

Relationship to Individual: ________________________________________________________

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**





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## MEDICAL RECORDS RELEASE FORM

Patient Name: ____________________________ DOB:______ ________________

By signing this form, I authorize San Joaquin Kidney Clinic, Inc. to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

**Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:**

Name: ________________________________________________________________

Address: ______________________________________________________________

City, State, Zip Code:___________________________________________________

**The purpose/reason for this release of information is as follows:**

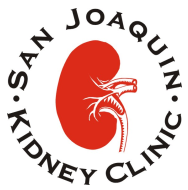
______________________________________________________________________

______________________________________________________________________

**Signature:**

_______________________________________ Dated: _____________________
Signature of Patient or Personal Representative

__________________________________________
Relationship to Patient

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## Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

**Uses and Disclosures**:

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain circumstances your protected health information can be discussed without your written authorization in certain limited circumstances are as follows:

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

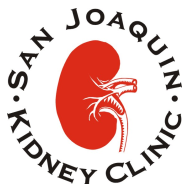
For any purpose other than treatment other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

**Patient Rights**:

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information. *
- You have the right to request in writing to amend, correct, or delete any recorded health information without our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

- Conditions and limitations may apply.

**Changes To This Notice:** We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated Notice will be posted and a copy will be sent to you.

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## NEW PATIENT REGISTRATION

-PLEASE PRINT –

Patient Name: ________________________ Sex: _______ DOB: ____________

Address: ______________________________________________ Home #: _____________________________ Work #: _________________

City________________________________ State____________ Zip Code____________________

Preferred Language: __________________________ SS#: ______________________________

Responsible Party if other than patient___________________________________________________________________________

Employer_________________________________________________________________________ Years________________

Address________________________________________________________________________________________________

City__________________________________ State________ Zip Code_____________ Phone #______________________________________

Spouse__________________________________ SS#___________________________________ Employer Phone #___________________________

Employer________________________________________________________________________________________________

Address________________________________________________________________________________________________

Please list below the names of individuals with whom we may discuss your health information:

Name Relationship (friend, relative, etc) Phone#

1.______________________________________________________________________________________________

2.______________________________________________________________________________________________

3.______________________________________________________________________________________________

By submitting this form, I hereby grant San Joaquin Kidney Clinic, Inc. permission to discuss my health information with the people listed above. All prior designations are hereby revoked.

Dated: _________________________

_______________________________________________
Signature of patient or legal Representative

_______________________________________________
Witness

IF the patient is a minor or has a personal representative, I represent that I am the legal Parent/Guardian/personal representative of the Patient named above and I am not prohibited by Court order from releasing access to the requested information.

_______________________________________________
Signature of Parent or Legal Representative

**INSURANCE AUTHORIZATION AND ASSIGNMENT**
******MEDICARE PATIENTS ONLY******

Name of Beneficiary:___________________________________ HIC #_____________________________________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by the Physician at San Joaquin Kidney Clinic, Inc.. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim if item 9 of the HCFA-1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown in Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_______________________________________________ Dated: _____________________________________________
Beneficiary Signature – MEDICARE PATIENT

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OFFICE USE ONLY
Form Received by:________________________________________
Date:__________________________________________
File this in the patient's medical record in the HIPPA file. Void all previous forms by drawing a line through the old form and initialing and dating the revocation.