3525 Ensign Road N.E., Suite K ■ Olympia, Washington 98506 ■ (360) 413-8121 ■ Fax (360) 413-8865

Patient Contact Information

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

____

____

Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

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____

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent **IF OTHER THAN YOUR HOME.**

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Please print the phone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: (____) ________________

Can confidential messages (i.e. appointments reminders) be left on your **home** answering machine or voicemail? ☐Yes ☐No

If you don't have voicemail, can a confidential message be left with whoever answers your **home** phone? ☐Yes ☐No
If no, whom specifically may we leave a message with?

____

May we contact you at work? ☐Yes ☐No

If yes, can confidential messages be left on your **work** answering machine or voicemail? ☐Yes ☐No

If you don't have voicemail, can a confidential message be left with whoever answers your **work** phone? ☐Yes ☐No
If no, whom specifically may we leave a message with?

____

Patient Name: ____

Last Name First Name Middle Initial

_______________________________________ _____________________

Patient or legally authorized individual signature Date

____

Relationship to patient if signed on behalf of the patient.

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Consent for Use and Disclosure of Health Care Information

Patient Name: ___________________________ Social Security #: __________________________

Date of Birth: ____________________________ Previous Name: ___________________________

My health information is a private matter. Memorial Nephrology Associates, PLLC has a form that can tell me how Memorial Nephrology Associates, PLLC handles my health information. This form is called "Notice of Privacy Practices". If I ask, Memorial Nephrology Associates, PLLC will be happy to provide me with the most current "Notice" before I sign this consent. Memorial Nephrology Associates, PLLC may update this "Notice" at any time. If I ask, I will get a copy of the most current "Notice". I agree that Memorial Nephrology Associates, PLLC may use and disclose my health information to help treat me. I agree that Memorial Nephrology Associates, PLLC may use or disclose my information for billing and payment. I also agree to uses and disclosures of my health information to take care of other health care operations. In general, there are no other uses or disclosures of my health information will occur unless I tell Memorial Nephrology Associates, PLLC it's okay. Sometimes the law may allow release of information without my permission. These situations are unusual. One example would be if a patient threatened to hurt someone. I can ask Memorial Nephrology Associates, PLLC to further limit the use or disclosure of my health information. Memorial Nephrology Associates PLLC is not required to agree to my request. If Memorial Nephrology Associates, PLLC agrees to any part of my request, Memorial Nephrology Associates, PLLC would have to follow the agreed limits. I may cancel this consent at any time, by doing one of the following:

- Signing and dating a revocation form. I may get this form from Memorial Nephrology Associates, PLLC; or
- Writing, signing, and dating a letter to Memorial Nephrology Associates, PLLC. The letter must say I cancel my consent to authorize the use and disclosure of my health information for treatment, payment and health care operations.

If I cancel this consent:

- It will be effective except for actions already taken based upon the Consent; and
- Memorial Nephrology Associates, PLLC will not have to provide any more health care services to me.

I have been given the chance to read a current copy of Memorial Nephrology Associates, PLLC's "Notice of Privacy Practices". I agree to allow Memorial Nephrology Associates, PLLC to use and disclose my health information to carry out treatment, payment, and health care operations.

____ _______________________

Patient or legally authorized individual signature Date

____

Relationship to patient if signed on behalf of the patient.