THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Privacy Practices

We may use and disclose your medical information, without your permission, for treatment, payment, and health care operations activities and, when required or authorized by law, for public health and interest activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your health care or payment for health care, and to appropriate public and private agencies in disaster relief situations.

We will not otherwise use or disclose your medical information without your written authorization. You have the right to examine and receive a copy of your medical information, to receive an accounting of certain disclosures we may make of your medical information, and to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Please specify the name of family or friends that the practice can speak with regarding medical or financial information.

Name	**Relationship**	**Date**
1._____		
2._____		
3._____		
4._____		

□ I DO CONSENT for Advanced Kidney Care of North Texas to leave detailed messages regarding my medical care including but not limited to lab/imaging results and appointment reminders. Please indicate best number to leave message: _____

□ I DO NOT CONSENT to leave detailed messages on my phone or answering machine or with any member of my family.

Patient Name: _____DOB: _____

Signature: _____ Date: _____

Signature if not patient: _____ Relation: _____ Date: _____