BANERJEE KIDNEY CENTER

HIPAA DISCLOSURE/ACKNOWLEDGEMENT FORM

Patient Name: ____DOB: ____________

Preferred Phone Number: _______________________________cell/work/home (Circle)

May we identify ourselves over the phone? O Yes O No

May we leave a message on the number above? O Yes O No

I, the patient, hereby authorize Banerjee Kidney Center to release my medical information (appointments, lab/imaging results, diagnosis, treatments, medications, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____________________________ DOB: __________ Relationship________________

Name _____________________________ DOB: __________ Relationship________________

Name: _____________________________ DOB: __________ Relationship________________

I further release my medical information to the following physicians, hospitals, etc.:

Doctor: __________________________City: ____________________Phone: ______________

Doctor: __________________________City: ____________________Phone: ______________

Doctor: __________________________City: ____________________Phone: ______________

Hospital: _______________________________Department: ___________________________

Hospital: _______________________________Department: ___________________________

Signature: ____Date: _______________