FRESENIUS MEDICAL CARE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: (_____)_____

A. Enter where the protected health information will be sent from and to:

***From* this Facility:**

Name: _____

Address: _____

City: _____ **State:** ____

Telephone Number: _____

PURPOSE: (check the appropriate box)
☐ Personal ☐ Legal ☐ Insurance
☐ Continued Medical Care
☐ Other_____

***To* the following:**

☐ **Directly to the patient**

☐ **To a legally authorized personal representative at the address below**

☐ **To a third party at the address below**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone Number: _____

B. I give my permission to share the following protected health information:

For Dates of Treatment (From): _____ (To): _____
Please indicate "All" if applicable.

Medical records may contain information regarding physical and mental illness, alcohol or drug dependency, HIV / AIDs or other sexually transmitted disease (STD), or genetic information. Such information may not be feasible to exclude depending on the scope of the request. If you do not consent to share such information through this Authorization, please discuss with the Facility whether it is feasible to exclude such information and, if so, modify the scope of your request.

Medical Record for Dates of Treatment Stated Above (select one)

☐ **Entire Medical Record**

☐ **Specific Protected Health Information** (please specify): _____
_____
_____
_____
_____

☐ ***FKC Only*: Care Transitions Report** (summary that includes current medications, allergies, recent dialysis treatment information, problem list, recent laboratory values and vascular access information)

☐ **Billing Record for Dates of Treatment Stated Above**

FRESENIUS MEDICAL CARE

Delivery Preference (if feasible):

☐ Pick Up in Person
☐ By Trackable Mail (Paper or Encrypted Media)
☐ E-mail (please enter email address):_____

Media Type (if feasible):

☐ Paper
☐ Electronic
☐ Fax: (___) _____

Patients may choose for medical and billing records to be delivered by email. Such information may not be secure and may be read by a third party depending on the recipient's security settings.

Expiration Date:

This authorization will expire one (1) year from the date of signing unless another date or event is specified here (such as "until the patient stops treating with FMCNA"): _____

C. I UNDERSTAND AND AGREE THAT:

I may decline to sign or I may revoke this authorization at any time for any reason. Doing so will not affect my treatment with FMCNA. If I decline to sign this authorization, my healthcare providers may continue to use and disclose my information for treatment, payment or other purposes to the extent permitted by federal and state law.

My signed authorization will remain in effect until it expires or until I (or my legally authorized personal representative) provide written notice to FMCNA that I revoke it. I may revoke this Authorization by notifying the Facility directly or the FMCNA Privacy Office by telephone (1-800-662-1237 ext. 4235), email (Privacy@fmc-na.com), or mail (Attn: FMCNA Privacy Officer, 920 Winter Street, Waltham, MA 02451). The revocation will be effective immediately when the Facility receives it, except the revocation will not have any effect on any prior action taken by the Facility in reliance on this Authorization.

I understand that once my protected health information has been disclosed to the authorized recipient, the information potentially may be re-disclosed to others who may not be required to abide by this Authorization or who are not subject to the same federal or state laws governing the use and disclosure of my health information.

I have read and understand the terms of this Authorization, and I have had an opportunity to ask questions.

_____ _____

Signature of Patient or Legally Authorized Personal Representative*** ***Date Signed***

_____ _____

Printed Name ***Relationship to Patient***

*** *If an incapacitated or deceased patient's personal representative submits this request, he or she must demonstrate authority under state law to access the patient's protected health information. Please provide such documentation to expedite the request.*

For incapacitated patients, the personal representative may rely upon a valid Health Care Power of Attorney or Proxy or court order. For deceased patients, the requirements vary by state. Some states require the court to appoint the personal representative as executor or administrator of the patient's estate in order to access medical records. Other states permit the deceased patient's spouse, adult child or other next of kin to obtain medical records pursuant to an affidavit that no other person has been appointed as executor or administrator.