

The Kidney and Hypertension Center
PERMISSION TO DISCUSS HEALTH INFORMATION WITH OTHER INDIVIDUALS

Date: _____

Unit #: _____

Name: _____

Office: _____

Please list the name(s) of individuals with whom we may discuss your health information:

Name	Relationship (friend,relative,etc.)	Phone #
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

By submitting this form, I hereby grant The Kidney and Hypertension Center to discuss my health information with the people listed above. All prior designations are hereby revoked.

Acknowledgement of Receipt of Notice Of Privacy Practices

The Kidney & Hypertension Center reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices from The Kidney and Hypertension Center.

Name of Patient (Print)

Signature of Patient or Legal Representative

Witness

Date