Texas Kidney INSTITUTE

Today's Date: _____

Patient Name: (last)_____ (first)_____(middle)_____

Date of Birth: _____ M____ F____ Patient's SS#: _____

Patient's Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____

Email Address:_____

Emergency Contact_____Phone_____Relationship_____

Privacy and Security Release

As a covered of the Health Insurance Portability and Accountability Act (HIPPA) Texas Kidney Institute, PA, and its business associates are protecting the privacy and security of your medical information. As such we do not release any information without your approval. This includes, but is not limited to medical and financial information. Please list any persons below, whom you are giving permission to have Texas Kidney Institute, PA, or its business associates, release information in regards to your care or billing.

_____ _____ ( ) Medical ( ) Financial

Person's Name Relationship

Primary Health Insurance **Does this insurance require pre-authorization? Yes_____ No_____**

Insurance_____Date Effective_____

Group#_____Ins ID_____

Policy Holder_____DOB_____SS#_____

Insurance Claim Address and Phone#:_____

Secondary Health Insurance **Does this insurance require pre-authorization? Yes_____ No_____**

Insurance_____Date Effective_____

Group#_____Ins ID_____

Policy Holder_____DOB_____SS#_____

Insurance Claim Address and Phone#:_____

I have received or read a copy of this office's Notice of Privacy Policy

_____ _____

Patient Signature/Guarantor **Date**

Texas Kidney Institute
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