Victoria Kidney & Dialysis Associates

Patient Authorization Form

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with Victoria Kidney & Dialysis's Notice of Privacy Practices that provides a complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Victoria Kidney & Dialysis reserves the right to change its Notice of Privacy Practices and will provide revised copy upon request, will post on the patient portal and in practice location. By signing this form, I consent to Victoria Kidney & Dialysis Associates' use and disclosure of my health information for treatment, payment, and health care operations.

Signature of Patient/Legal Representative_____ Date_____

INFORMED CONSENT FOR ELECTRONIC TRANSFER OF MEDICAL DATA

I hereby give permission to Victoria Kidney & Dialysis Associates to release a clinical summary of my medical records to any physician or medial facility that has direct involvement with my care. I understand this information will remain strictly confidential and this authorization will remain in effect until revoked by me in writing.

Signature of Patient/Legal Representative_____ Date_____

INFORMED CONSENT FOR PRESCRIPTIONS

I hereby consent to my prescription history form Victoria Kidney & Dialysis Associates being shared in the electronic prescription database for drug interaction monitoring.

Signature of Patient/Legal Representative_____ Date_____

Witness of Signature _____ Date _____