MIDWEST NEPHROLOGY CONSULTANTS, P.A. PRIVACY NOTICE PATIENT ACKNOWLEDGEMENT/ TELEPHONE CONTACT

ALEXIS G. THOMAS, M.D., F.A.C.P
HARRIET S. LANGLEY, M.D., F.A.C.P
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BRENNA JOHNSTON, MSN, APRN-C
NANCY DELACRUZ, MS, APRN-C
DIANA MYERS, MSN, APRN-C

I, _____ have received a copy of Midwest Nephrology Consultants Privacy Policy.

_____ _____
Patient / Guardian or Representative Signature Date

The primary contact phone numbers for our authorized staff to leave confidential, detailed medical messages in order to manage your specific medical condition while under the care of Midwest Nephrology Consultant physicians are:

_____ _____.
Primary telephone number Secondary telephone number

Additionally, I understand and agree to disable any call blocking feature from the above listed telephone numbers.

I, _____ give consent to Midwest Nephrology for the next 365 days, (unless revoked by me sooner) to ***disclose or discuss detailed medical information and/or billing information*** with the following person or persons. **Please mark all that apply:**

☐ Spouse: _____ ☐ Father: _____

☐ Mother: _____ ☐ Daughter: _____

☐ Son: _____ ☐ Sister: _____

☐ Brother: _____

☐ Power of Attorney: _____
Document must be on file.

☐ Legal Guardian: _____
Document must be on file.

☐ Executor and/or Trustee: _____
Document must be on file.

☐ Other: _____
Document must be on file and/or approved by the Administrator and/or the Nursing Coordinator.

_____ (Initial) I understand this is time specific, and in order for information to be released a current HIPAA notice must be on file.

**********Subsequent visits: do not complete unless requested**********

1._____ (Initial) I have checked all information and requested no changes be made at the time. Please extend this request for an additional 365 days. This will end _____ (date) unless revoked by me sooner.

2._____ (Initial) I have checked all information and requested no changes be made at the time. Please extend this request for an additional 365 days. This will end _____ (date) unless revoked by me sooner.

After the above date has expired or is revoked by me, I am aware a new HIPAA request must be filled out.

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