The Kidney Group

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

_____ _____ _____

(Last Name) (First Name) (M.I.)

D.O.B.: _____/_____/_____

ADDRESS: _____

_____

_____

TELEPHONE: _____

I, _____, have had full opportunity to read and consider the contents of this consent form and notice of privacy practices. I understand that, by signing this consent form, I am giving my consent for disclosure of my protected health information in order that treatment, payment activities, and healthcare operations may be carried out.

SIGNATURE: _____ DATE: ___/___/___