HealthCare Partners
A DaVita Medical Group

HIPAA CONTACT DISCLOSURE

I,_____ (DOB)_____, give Dr._____
and staff, authorization to disclose my protected health information to the following family, friends and/or caregivers:

Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____

In the event HealthCare Partners of Nevada may need to give your test results or medical information, may we……(check all that apply)

_____ Leave a detailed voice message on this phone, the number is _____.
_____ Call you on your cellular phone, the number is_____
_____ Call you at work, the number is_____
_____ Speak to you directly. **ONLY**

Disclaimer: Certain Sensitive health information (treatment / testing) are specifically protected and will not be disclosed outside of the clinic setting without specific authorization. This includes the following:

- Mental / behavioral Health records
- Alcohol / drug dependency treatment
- HIV testing results / AIDS treatment
- Sexually transmitted disease (STD)
- Genetic testing / test results

Please indicate if you allow or deny HealthCare Partners the ability to share this information with you, per the indicated communication option above.

I **allow** HealthCare Partners to share sensitive health information as noted above per the communication options checked on this form. _____ (Patient Signature)

I **DO NOT allow** HealthCare Partners to share sensitive health information as noted above.
_____ (Patient Signature)

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Medical Records department.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. HealthCare Partners and its entities will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices, which I obtained from my doctor's office.
Unless, otherwise revoked, this authorization will expire on the following date, event or condition:
_____

If I fail to specify a date this authorization will expire one (1) year from the signature on this form.

_____Date_____
Signature of Patient

_____Date_____
Signature of Guardian or Personal Representative

_____Date_____
Signature of HealthCare Partners of Nevada Employee