SAN ANTONIO KIDNEY

PATIENT FORM

PATIENT INFORMATION			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Contact Preference ☐ Home Phone ☐ Work Phone ☐ Cell Phone	May we leave you a message regarding medical care & test results? ☐ Yes ☐ No		
Email	Social Security No	Gender Male ☐ Female ☐	
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Black/African American ☐ White ☐ Hawaiian/Pacific Islander ☐ More than one	Ethnicity ☐Hispanic/Latin Descent ☐Not Hispanic/Latin Descent	
Primary Care Physician	Referring Physician		
Reason for your visit today			
Other physicians involved in your care			
Pharmacy Name	Pharmacy Address/Crossroads	Pharmacy Phone ( )	
Occupation	Employer		
Emergency Contact	Emergency Contact Phone ( )	Relationship	

RELEASE OF MEDICAL INFORMATION	☐ **Do not release my information to anyone**	
Name	Phone ( )	Relationship
Name	Phone ( )	Relationship

INSURANCE INFORMATION		
Primary Insurance Company	Insurance Company Address	
Policy Holder Name	Policy Holder Date of Birth	Policy Holder Employer
Identification Number	Group/Policy Number	
Secondary Insurance Company	Insurance Company Address	
Policy Holder Name	Policy Holder Date of Birth	Policy Holder Employer
Identification Number	Group/Policy Number	

PAST MEDICAL HISTORY (Check all that apply; fill in dates where appropriate)

Kidneys/Bladder/Prostate

☐ Frequent Urinary Tract Infections (>2-3/year)
☐ Episodes of Pyelonephritis (Kidney Infection)
☐ Kidney Stones
☐ Enlarged Prostate
☐ History of Acute Kidney Failure, Date: _____
☐ Blood in the Urine, Date: _____
☐ Protein in the Urine, Date: _____
☐ Incontinence
☐ Overactive Bladder
☐ Kidney Cysts/Polycystic Kidneys

Head, Ears, Nose, Throat

☐ Hearing Loss
☐ Vision Loss
☐ Glaucoma
☐ Cataracts
☐ Macular Degeneration
☐ Excessive Dry Eyes
☐ Nose Bleeds
☐ Nasal Allergies/Congestion
☐ Headaches
☐ Head Trauma

Cardiovascular

☐ Hypertension, Year of Diagnosis: _____
☐ Coronary Artery Disease
☐ Myocardial Infarction (Heart Attack), Date: _____
☐ Congestive Heart Failure
☐ Atrial Fibrillation
☐ Ventricular Arrhythmias
☐ Pacemaker/Defibrillator Placement
☐ Peripheral Vascular Disease (poor circulation to legs)
☐ Valve Disease:
☐ Aortic ☐ Mitral ☐ Tricuspid ☐ Pulmonary
☐ Edema (Swelling)
☐ Aneurysm

Lungs

☐ Emphysema/Bronchitis/COPD
☐ Asthma
☐ Tuberculosis
☐ Pulmonary Hypertension

Endocrine and Glandular Disorders

☐ Diabetes Mellitus, Type: I ☐ II ☐
Year of Diagnosis: _____
☐ Underactive Thyroid ☐ Overactive Thyroid
☐ High Cholesterol
☐ Obesity

Gastrointestinal

☐ Stomach Ulcer
☐ Acid Reflux/Heartburn
☐ Diverticulosis/Diverticulitis
☐ GI Bleeding
☐ Liver Disease/Cirrhosis
☐ Hepatitis A ☐ B ☐ C ☐ /Jaundice
☐ Pancreatitis
☐ Colon Polyps
☐ Hemorrhoids

Blood and Oncology

☐ Cancer/Tumor, Location: _____
Date: _____
Chemotherapy? Yes☐ No☐, Radiation? Yes☐ No☐
☐ Blood Clots
☐ Anemia
☐ Blood Transfusion
☐ Bleeding Disorder
☐ Thrombocytopenia
☐ Leukemia/Lymphoma

Musculoskeletal Disorders

☐ Arthritis: ☐ Osteoarthritis ☐ Rheumatoid
☐ Lupus
☐ Gout
☐ Low Back Pain
☐ Osteoporosis
☐ Use of Non-Steroidal Anti-Inflammatories (NSAID)

Skin Disorders

☐ Psoriasis
☐ Dry Skin
☐ Skin Ulcers

Neurologic/Psychiatric

☐ Seizures
☐ Strokes
☐ TIA (Mini-Strokes)
☐ Migraines
☐ Tremor
☐ Neuropathy
☐ Vertigo
☐ Depression
☐ Anxiety or Panic Attacks
☐ Bipolar Disorder
☐ Excessive Alcohol Use/Alcoholism
☐ Illegal Drug Use

PAST SURGICAL HISTORY (Check all that apply and provide dates where possible)

☐ Cholecystectomy (Gall Bladder Removal)
☐ Appendectomy
☐ Tonsillectomy/Adenoidectomy
☐ Reduction of Fracture
☐ Hysterectomy
☐ Mastectomy Left ☐ Right ☐
☐ Cataract Extraction Left ☐ Right ☐
☐ Other (list type and date) _____

☐ Coronary Artery Bypass:
Vessel 1☐ 2☐ 3☐ 4☐ 5☐ 6☐
☐ Leg Bypass Left ☐ Right ☐
☐ Colectomy Partial ☐ Total ☐
☐ Hernia Repair:
Inguinal ☐ Left ☐ Right☐; Incisional ☐, Ventral ☐

_____

_____

ALLERGIES TO MEDICATIONS

Name of Medication (ex: Codeine)	Description of Reaction or Accompanying Symptoms

MEDICATION LIST

Please list all current prescription and over-the-counter (OTC) medications you are currently taking or attach a copy of your current list of medications. Include hormones, birth control pills, vitamins, supplements, calcium, and special dietary aides. Also include medications that have been discontinued in the last 3 months and the date is was discontinued.

Medication Name	**Dosage**	**Frequency**	**Prescribing Doctor**
(e.g. Lisinopril)	(e.g. 40 mg, 20 units)	(e.g. 1 tablet twice a day)	(e.g. Dr. Smith)

FAMILY HISTORY

Relative	Living	Age or Age of Death	List Illnesses and/or cause of death
Mother	Y☐ N☐		
Father	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		

SOCIAL HISTORY

Current Occupation: _____

Employer: _____ Hours worked each week: _____

Previous Occupation: _____

Are you disabled? Yes☐ No☐ If so, date and why: _____

Highest Level of Education Completed: _____

Marital Status: Married☐ Single☐ Divorced☐ Widowed☐

Who do you live with? _____

Do you drink alcohol? Yes☐ No☐ If yes, what do you drink? Beer☐ Wine☐ Liquor☐,
How many drinks in average week? _____

Have you quit drinking? Yes☐ No☐ If so, when did you quit? _____ How many drinks in average week? _____

Do you smoke? Yes☐ No☐ If yes, how many packs/day? _____

Have you quit smoking? Yes☐ No☐ If yes, how many packs/day? _____ Age started: _____Age quit: _____

Do you or did you ever smoke cigars, pipes, or chew tobacco? Yes☐ No☐

Do you or did you ever use street drugs (Cocaine, Marijuana, LSD, Speed, IV Drugs, etc.)? Yes☐ No☐

Do you drink coffee or caffeinated sodas frequently (< 2 per day)? Yes☐ No☐ If yes, how much each day? _____

HEALTH MAINTENANCE

☐ Colonoscopy, Date: _____

☐ Flu Vaccine, Date: _____

☐ Covid Vaccine, Date:

☐ Mammogram, Date: _____

☐ Pneumonia Vaccine, Date: _____

REVIEW OF SYMPTOMS (check all that apply, clarify below if needed)

General
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight gain/loss (> 10 lbs.)
- ☐ Recent Hospitalization
- ☐ Recent Illness
- ☐ Poor Appetite

Skin
- ☐Rashes
- ☐Excessive Itching
- ☐Ulcers on Skin
- ☐Skin Color Changes
- ☐Excessive Sweating

Head, Eyes, Ears, Nose, Throat
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Sudden Change in Vision
- ☐ Excessively Dry Eyes
- ☐ Frequent Bloody Nose
- ☐ Recurrent Nasal Congestion
- ☐ Ulcers in mouth/lips
- ☐ Dry Mouth

Neck
- ☐Neck Mass
- ☐Neck Swelling
- ☐Swollen Glands

Lungs
- ☐Shortness of Breath
- ☐Wheezing
- ☐Chronic Cough
- ☐Bloody Sputum

Heart
- ☐Chest Pain
- ☐Swelling of Feet
- ☐Irregular Heart Beat
- ☐Cramps in Legs with Walking
- ☐Heart Murmurs
- ☐Fainting or Passing Out
- ☐High Blood Pressure
- ☐Excessively Low Blood Pressure
- ☐Heart Stent
- ☐Pacemaker
- ☐Wake up at Night Short of Breath
- ☐Short of Breath Lying Flat in Bed

Stomach/Intestines
- ☐Abdominal Pain
- ☐Blood in Stool
- ☐Black Tarry Stools
- ☐Nausea &/or Vomiting
- ☐Diarrhea
- ☐Frequent Heartburn
- ☐Jaundice
- ☐Polyps

Kidneys/Bladder
- ☐ Blood in the Urine
- ☐ Urgency or Overactive Bladder
- ☐ Burning or Pain with Urination
- ☐ Urinate frequently (more than usual)
- ☐ Flank Pain
- ☐ Hesitancy or incomplete emptying
- ☐ Incontinence
- ☐ Excessive Urination at Night
- ☐ Foamy Urine

Men
- ☐Problems with Erections
- ☐Weak or Slow Urinary System

Women
- ☐Lump or Mass in Breast
- ☐Nipple Discharge
- ☐Excessive Menstrual Bleeding

Muscles/Joints/Bones
- ☐Frequent Gout Attacks
- ☐Joint Pain
- ☐Joint Stiffness
- ☐Joint Swelling
- ☐Muscle Pain
- ☐Muscle Weakness

Nerves/Brain
- ☐Numbness or Tingling
- ☐Dizziness or Vertigo
- ☐Seizures
- ☐Tremors or Shaking
- ☐Memory Loss
- ☐Balance Problems/Falls

Psychiatric
- ☐Depression
- ☐Anxiety
- ☐Insomnia/Trouble Sleeping

Endocrine/Glands
- ☐ Thyroid Problems
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst

Blood/Lymph Nodes
- ☐Anemia/Low Blood Count
- ☐Easy Bruising
- ☐Easy Bleeding
- ☐Enlarged Lymph Nodes

Explanation: _____

SAN ANTONIO KIDNEY

PATIENT AUTHORIZATION FORM

RELEASE OF MEDICAL INFORMATION	INITIALS
I authorize San Antonio Kidney to release or disclose any protected health information about me to carry out treatment, payment and healthcare operations.	

CONSENT OF TREATMENT	INITIALS
I authorize the health care providers at San Antonio Kidney to perform a physical examination and provide me (or the patient I represent) any medical treatment deemed necessary.	

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS	INITIALS
I understand I am ultimately responsible for payment on my account. I understand it is my responsibility to provide insurance information, to include any changes, to San Antonio Kidney. I understand I am responsible for any referral or authorizations that my insurance may require and for any charges not covered by my insurance, to include co-payments, deductibles and coinsurance. I authorize payment of benefits to be paid directly to San Antonio Kidney. I understand I am financially responsible for any balances and charges not covered by this assignment.	

NOTICE OF PRIVACY PRACTICES	INITIALS
I acknowledge San Antonio Kidney has provided me a copy of the Notice of Privacy Practices which explains how my Protected Health Information (PHI) may be used and/or disclosed.	

_____

Print Patient Name

_____ _____

Signature of Patient or Legal Representative Date

SAN ANTONIO KIDNEY

RECORDS RELEASE REQUEST

PATIENT INFORMATION				
First Name	Last Name	MI	Social Security Number	Date of Birth
Address	City	State	Zip	

I hereby authorize and request the following doctor/facility release the below checked items to San Antonio Kidney:

☐ My complete medical record

☐ Records of care from timeframe: _____ to _____ only

☐ Records of care concerning the following condition(s): _____

_____ _____

Patient Signature Date

RECORDS RELEASE FROM:			
Doctor/Facility			
Address	City	State	Zip
Phone Number ( )	Fax Number ( )		

RECORDS RELEASE TO: San Antonio Kidney					
☐ 102 Palo Alto Rd, Ste 200	San Antonio	TX	78211	P (210) 403-0765	F (210) 547-9270
☐ 1410 E. Walnut St	Seguin	TX	78155	P (830) 549-5022	F (830) 433-4460
☐ 222 Sidney Baker South, Ste 208	Kerrville	TX	78028	P (830) 896-7607	F (830) 896-8482
☐ 2391 NE Loop 410, Ste 405	San Antonio	TX	78217	P (210) 654-7326	F (210) 590-8232
☐ 2660 E. Common St, Ste 201	New Braunfels	TX	78130	P (830) 620-4650	F (830) 620-4657
☐ 2902 Goliad Rd, Ste 103	San Antonio	TX	78223	P (210) 337-4911	F (210) 337-7749
☐ 400 Baltimore	San Antonio	TX	78215	P (210) 228-0743	F (210) 228-9749
☐ 495 10th Street, Ste 102	Floresville	TX	78114	P (830) 216-2606	F (830) 216-4037
☐ 18707 Hardy Oak Blvd, Ste 530	San Antonio	TX	78258	P (210) 495-8280	F (210) 481-3116
☐ 4330 Medical Dr, Suite 105	San Antonio	TX	78229	P (210) 692-7228	F (210) 692-9671
☐ 10010 Rogers Crossing, Ste 210	San Antonio	TX	78251	P (210) 549-3524	F (210) 549-3526

Instruction A: Insert the covered entity's name

Instruction B: Insert the covered entity's address, web site and privacy official's phone, email address, and other contact information.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Instruction C: Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."

Instruction D: The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.

Instruction E: If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.

To leave this section blank, add a word space to delete the instructions.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Instruction F: Insert Effective Date of Notice here.

This Notice of Privacy Practices applies to the following organizations.

Instruction G: If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

Instruction H: Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.

SAN ANTONIO KIDNEY

Please Send Signed Consent to: Fax – (210) 481-7453, Email – medicalrecords@sakdc.com, or
Mail to; San Antonio Kidney, 7142 San Pedro Ave., Ste. 120, San Antonio, TX 78216

San Antonio Kidney
Telemedicine Consent

Patient Name: _____

Account Number: _____

Date of Birth: _____.

I. Introduction. Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

II. Consent for Treatment. I voluntarily request San Antonio Kidney Physician(s), Nurse Practitioners, and other health care providers as they may deem necessary participate in my medical care through the use of telemedicine.

I understand that San Antonio Kidney Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that San Antonio Kidney Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

If San Antonio Kidney Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my treating physician and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

III. Release of Information. To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to San Antonio Kidney Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information: 2) drug screen results and information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.

I understand that the disclosure of my medical information to San Antonio Kidney Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

_____ _____

Signature of Patient/Responsible Party (Relationship to Patient) Date

Please Send Signed Consent to: Fax – (210) 481-7453, Email – medicalrecords@sakdc.com, or
Mail to; San Antonio Kidney, 7142 San Pedro Ave., Ste. 120, San Antonio, TX 78216