

**NANI**  
**Nephrology Associates of Northern Illinois**

Please print

1. Patient Name (Last, First, Middle)	2. Sex  ) Male ) Female	3. Date of birth
4. Social security number	5. Phone number (include area code)  Home: May we leave message?  Work: May we leave message?	6. Address (Street, City, State, Zip)
7. Primary Insurance Carrier	8. Insured policy & group number	9. Name of insured
10. Relationship to insured  <input checked="" type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other	11. Insured date of birth (other than self)	12. Insured Address (other than self)
13. Secondary Insurance Carrier	14. Insured policy & group number	15. Name of insured
16. Referring physician	17. Emergency contact (name & relation) <b>*see below*</b>	18. Emergency contact phone number

**Consent for release and use of confidential information and receipt of notice of privacy practices**

I, the patient listed below, hereby give my consent to Nephrology Associates of Northern Illinois to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my medical record. I understand that I am financially responsible to pay Nephrology Associates of Northern Illinois for services not reimbursed by any third party payor, including reasonable attorney's fees and the costs of collection. I acknowledge availability of the physician's notice of privacy practices. The notice of privacy practice provides detailed information about how the practice may use and disclose my confidential information. I acknowledge that I may request a copy of this at any time. I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be available to me at the physician's office location. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information.

\*\*I hereby give permission to Nephrology Associates to release/discuss any part of my medical care with the emergency contact/s listed above. I understand I can revoke this permission in writing at any time.

Patient \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient