FRESENIUS KIDNEY CARE

HIPAA AUTHORIZATION FORM

Full Name: _____

Date of Birth: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

I authorize my health care providers with Fresenius Medical Care Holdings, Inc. a/k/a Fresenius Medical Care North America ("FMCNA"), including Fresenius Kidney Care, to disclose my personal medical and billing information to SelectQuote, an independent licensed insurance agency, with certain limitations listed below.

I allow FMCNA to share my information with SelectQuote to assist me in identifying potential health insurance options, including Medicare Advantage. I authorize the following to be shared: my name, contact information, date of birth, medical provider(s), medications, and current health insurance or payment information, including participation in any financial assistance programs. I also authorize a Select Quote representative to contact me.

I may refuse to sign, or I may revoke this Authorization at any time and for any reason. If I do so, FMCNA may continue to use and disclose my information to other recipients if permitted by federal and state law, such as to facilitate my dialysis treatment.

My signed Authorization will remain in effect until I provide written notice that I revoke this Authorization or for one year, whichever comes earlier. I may revoke this Authorization by notifying the FMCNA Privacy Office by phone (1-800-662-1237 ext. 4235), email (Privacy@fmc-na.com) or mail (Attention: FMCNA Privacy Officer, 920 Winter Street, Waltham, MA 02451). The revocation will be effective immediately once FMCNA receives my written notice, except it will not have any effect on FMCNA's disclosures to SelectQuote before my revocation.

I understand that once my health information has been disclosed to SelectQuote, SelectQuote may potentially re-disclose the information to others who may not be required to follow the same federal or state laws as FMCNA regarding my health information.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions. By my signature, I authorize FMCNA to use or disclose my health information in the manner described.

_____

Signature of Individual ***Date Signed***

_____

Printed Name

Thrive On