Kidney Care Specialists LLC - Nephrology Associates Division

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AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

I authorize Kidney Care Specialist LLC - Nephrology Associates Division to RELEASE/OBTAIN medical information from my medical records to / from:

Name of Doctor/Practice/Hospital/etc: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

For the purpose of review/examination, and I authorize you to provide such copies as may be requested. The foregoing is subject to such limitations as indicated below:

_____ Entire Record
_____ Specific Information: _____
_____ Last (___) Year(s) Only

This authorization will automatically expire in six months from the date signed. I understand that I may revoke this consent at any time.

Reason for Request:
_____

Patient's Signature: _____ Date: _____

Witness: _____ Completed By: _____