NEPHROLOGY ASSOCIATES

Compassionate Kidney Disease Diagnosis and Treatment
Promoting Quality of Life + Independence

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth:_____

Address: _____

Phone Number:_____ Treatment dates from_____to_____

I authorize Nephrology Associates, P.C. to release copies of my medical records to:

Physician/Facility Name:_____

Address: _____

Office Phone Number: _____ Office Fax Number:_____

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release Nephrology Associates, P.C. from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse.

Patient (or legal representative) Signature: _____

Date: _____ Relationship to Patient:_____

Witness:_____