AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

NEPHROLOGY & HYPERTENSION

2402 Camden Street, Suite 700 • Wilson, NC 27893
Phone: 252.293.9898 • Fax: 252.293.9915

4082 Capital Drive • Rocky Mount, NC 27804
Phone: 252.293.9898 • Fax: 252.293.9915

I, ______________________________ ______________ ______________

Name of Patient | Date of Birth | Maiden Name

AUTHORIZE:	TO DISCLOSE TO:
Name ____________________	Name ____________________
Address ____________________	Address ____________________
City/State/Zip ____________________	City/State/Zip ____________________
Phone # ____________________	Phone # ____________________
Fax # ____________________	Fax # ____________________
Email ____________________	Email ____________________

Please release the following medical information on the above referenced patient:

[ ] Information related to the following:

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[ ] Information obtained during the following time period (specify exact dates):

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This disclosure is being made for the following purpose(s):

❑ Continuing care ❑ Transfer of care ❑ Attorney/Court Case ❑ Insurance ❑ Workers' Comp

I understand that this authorization is subject to revocation at any time by written notification except to the extent that the facility which is to make the disclosure has already acted in reliance on it. Information documented in my records after the date of my signature will not be released. I understand that the information released cannot be disclosed.

______________________________ ______________ ______________

Signature of Patient/Legal Representative | Date | Photo ID#

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Witness Signature