AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I authorize you to release to: Nephrology Consultants, L.L.C.

All records: including Labs, Renal Ultrasounds and Physician Notes

_____
Patient Signature / Parent Signature if patient is a minor

_____
Print Patient Name

_____
Date of Birth

_____
Social Security Number

_____
Witness

FOR OFFICE USE ONLY:

DATE: _____

TO: _____

PHONE: _____ / FAX:_____

REQUESTED BY: ☐ Todd Broome, MD ☐ David Tietjen, MD ☐ Roger Coomer, MD
☐ John Clark, MD ☐ Michael Quadrini, MD ☐ Carlo Castillo, DO ☐ David Bains, MD

Attn: _____