# AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Address _____ City, State, Zip _____

**I, authorize**

Name _____

Address _____

City, State, Zip _____

to disclose the following medical information to:

**Nephrology and Hypertension Specialists, LLC**

THE AUTHORIZATION EXTENDS ONLY TO DOCUMENTS INITIATED BELOW:

_____ Record of Visits From _____ To _____

_____ Progress Notes From _____ To _____

_____ Consultation Reports

_____ History of Physical Examination

_____ Lab Results Type of Test _____ Date _____

_____ X-Ray Reports Date Taken _____

_____ Discharge Summary Date of Discharge _____

_____ AIDS (Acquired Immunodeficiency or HIV (Human Immunodeficiency Virus) Information

_____ Hepatitis Information

_____ Other (Must be specific)

_____ All of the Above