Authorization to Release Medical Information

PATIENT INFORMATION

Patient Name: _____ _____ _____ **DOB**: ____/____/_____
FIRST NAME MI LAST NAME MM DD YYYY

Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Tel: _____ **HOME** **SSN**: _____ **Gender**: Male ___ Female ___

PATIENT AUTHORIZATION

I, _____, hereby authorize the Nephrology Center of Maryland to receive any and all
PRINT FIRST and LAST NAME
medical information about me. Good health care is always a team effort, and I understand that the Nephrology Center of Maryland will obtain such information so that the respective Nephrologist(s) can take an active role to create a treatment plan and to facilitate the appropriate delivery of health care services with my coordination of care team.

_____ _____
NAME OF PATIENT (PLEASE PRINT) DATE

_____
SIGNATURE OF PATIENT