JACKSONVILLE NEPHROLOGY
Kidney Diseases and Hypertension

Authorization to Release Medical Records

Patient Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy):_____

Address: _____City:_____State:_____Zip:_____

Phone: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient:

Information needed for:	**Information to be released:**
□ **Continuing medical care**	□ **Last progress note**
□ **Transfer of care**	□ **Laboratory results**
□ **Other (specify):**	□ **Imaging Studies**
_____	□ **Pathology Report**
	□**Procedure Report**

The above information may be released:

FROM Whom: **Physician Name**: _____

Practice Name:_____

Phone/Fax:_____

TO Whom: **Jacksonville Nephrology**
13241 Bartram Park Blvd., Suite 1001
Jacksonville, FL 32258
P (904) 260-9898 FAX (904) 260-9891

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV/AIDS.
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Date: _____ Signature:_____

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient