Authorization For Release of Medical Records

North Texas Kidney Consultants
3030 Matlock Road
Suite 205
Arlington, Texas 76015

PHONE:(817) 375-0610 FAX:(817) 375-0640

Patient Name _____

SS#: _____ **DOB:**_____

Receive Records From:

_____
_____
_____
_____

Release Records To:

_____
_____
_____
_____

Please send a copy of my records as indicated for date(s) of treatment: _____

_____Hospital Records _____Lab Reports _____ Imaging Reports _____ Office Notes _____All Records

Purpose for releasing
Medical information:_____

_____

Signature of Patient/Legal Guardian **Date**

Witness **Date**

This authorization expires ninety(90) days from the date of signature.