The Kidney Clinic, LLC

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Request for Access to Records

Please fax / mail the requested records to the **SNELLVILLE** office at the fax / address listed above.

Patients Name: ____ Date of Birth: ________________________

Address: ____ Phone Number: _______________________

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I hereby authorize ____ to release the health information requested
(Name of current physician or facility)
below contained in my medical record to The Kidney Clinic, LLC.

Records Requested:

☐ Last Office Note and Labs	☐ Medication List
☐ History and Physical	☐ Labs
☐ Radiology/Imaging Reports	☐ Demographics and Insurance Info
☐ Entire Medical Chart (all office notes, face sheets, labs, radiology reports, etc)	
☐ Other:	

Limits on the information you may release subject to this Release Form are as follows: ____________________

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☐ Check this box ONLY if you do NOT consent to the release of drug, alcohol, HIV/AIDS, and/or psychiatric information.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that my health care will not be affected if I do not sign this form.

Patients Signature: ____ Date: ____________________________