JACKSONVILLE NEPHROLOGY
Kidney Diseases and Hypertension

Authorization to Release Medical Records

Patient Name (Last name, First name): **Date of Birth (mm/dd/yyyy):**

Address: **Phone:**

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

Information to be Released:
□ **Last Progress Note**
□ **Laboratory Results Within the Past Six (6) Months**
□ **Hospital Patients ONLY: Most Recent Discharge Summary**
□ **Other (specify below):**

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
PHONE (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.

Signature of Patient or Legal Representative	
Print Name	Relationship of Legal Representative