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**AUTHORIZATION TO OBTAIN MEDICAL RECORDS FROM TREATING MEDICAL PROVIDERS AND FACILITIES**

**I HEREBY AUTHORIZE** Maryland Kidney Group, P.A. to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that have provided care as my treating physician or facility.

\_\_\_\_\_  
 Patient Name Print & Signature

\_\_\_\_\_                                  \_\_\_\_\_                                  \_\_\_\_\_  
 Date    Date of Birth    Phone Contact Number

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS**

In accordance with Federal Government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of Maryland Kidney Group, P.A. to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

\_\_\_\_\_ I do not authorize Maryland Kidney Group, P.A. to release any information concerning my medical care to any individual except as set forth above.

\_\_\_\_\_ I do authorize Maryland Kidney Group, P.A. to release any or all information concerning my medical care to the following individual(s):

_____ Name- Please Print	_____ Name—Please Print
_____ Relationship to patient	_____ Relationship to patient
_____ Phone number	_____ Phone number
_____ Patient Signature	_____ Date

.....  
 Maryland Kidney Group has my permission to leave a voice mail message regarding my health information or my results at my phone # \_\_\_\_\_. Please initial: \_\_\_ YES \_\_\_ NO