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Nephrology and Hypertension Specialist
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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER PROVIDERS AND/OR FACILITIES

I, _____ hereby authorize,
(Name of Patient)

_____ Fax#_____
(Name of physician and/or facility) ` (Fax# of location requesting from)

to release the following medical information to Dr. Gampala Reddy

information to be released marked with an (X) below:

Labs _____ ➡ From _____ to _____ Specifics_____
(Date) (Date)

Imaging _____ ➡ From _____ to _____ Specifics_____
(Date) (Date)

Notes _____ ➡ From _____ to _____ Specifics_____
(Date) (Date)

Additional information requested:_____

This information is being released only for the purpose for continuation of care and may not be used for any other purpose without my written consent.
This release is effective as dated below. However, it may be revoked by me at any time by providing notice in writing to the above-named party.

Signature_____ Date_____

Printed Name_____ Date of Birth_____