Authorization for Release of Medical Records

Patient Name **Date of Birth**

I authorize We Care Nephrology, LLC to:

☐ Release to ☐ Receive from

Name of Provider

Provider Contact

Address

Information to be disclosed:

I authorize the release of the following health information:

☐ **All medical records**

☐ **Other (please specify below)**

Authorization

I understand that my medical records can not be disclosed without my written authorization; that this authorization will automatically expire one year from the date signed, and that I may revoke this consent at any time by notifying We Care Nephrology in writing.

Patient Name (Printed) ______________________________ **Date** ______________________

Patient Signature ______________________________

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian (Printed) ______________________________ **Date** ______________________

Guardian's Signature ______________________________ **Legal Relationship** ______________________