NORTHWEST NEPHROLOGY CLINIC

HYPERTENSION AND NEPHROLOGY

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AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION

I, the undersigned patient/guardian, hereby authorize ____to

Release information listed below from the records of____.

The release of information to which I consent is for the purpose of________________________________

____

For the following dates of hospitalization or outpatient services:__________________________________

____

I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.

____
Signature of Patient/Guardian

____
Date of Signature

____
Relationship to Patient

____
Signature of Witness