



Advanced Kidney Care of North Texas

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Plano Office

4708 Alliance Blvd.
Suite 600
Plano, TX 75093
Phone (469) 467-0011
Fax (469) 467-4923

McKinney Office

5236 West University Drive
Suite 4200
McKinney, TX 75071
Phone (214) 544-9590
Fax (214) 544-9595

Garland Office

7150 N. President George Bush Hwy
Suite 205
Garland, TX 75044
Phone (972) 276-0139
Fax (972) 276-0149

Patient Name (Print): _____

DOB: _____

Receive Records From:

Release Records To:

Please send a copy of my records as indicated for date(s) of treatment: _____

_____ Hospital Records _____ Lab Reports _____ X-Ray/Imaging Reports
_____ Office Notes _____ All Records

The purpose of this disclosure is for:

- Continuity and coordination of medical care
- Other

I authorize Advanced Kidney Care of North Texas to send and/or retrieve my records via the "Patient Record Sharing" system.

This authorization will continue throughout the course of my treatment unless revoked by me in writing.

Signature of Patient, Parent or Legal Guardian

Date

Witness

Date