Release of Medical Information

Patient Name (printed) _____

Date of Birth _____

Records Release From:

Kathleen A. Doman, M.D.
Shalini Mundra, M.D.
Manish Goyal, M.D.
Nephrology and Hypertension Consultants, P.A.
8401 University Exec. Park Dr., Ste 123
Charlotte, North Carolina 28262
Phone: 704-503-4400 Fax: 704-503-4030

Records Released to: _____

Attn: _____ Record/Case Number: _____

Fax: _____ Phone: _____

I authorize the Release of the following records to the Company/Individual listed above.

- ☐ History and Physical _____
- ☐ Progress Notes _____
- ☐ Hospital Discharge Summary _____
- ☐ Consults _____
- ☐ Labs _____
- ☐ Medication List/Log
- ☐ Pathology _____
- ☐ Radiology _____
- ☐ EKG _____
- ☐ Demographic/Billing Information
- ☐ Other: _____

I understand that this authorization allows the release of my medical records including information concerning my chemical dependency, positive HIV, AIDS, and/or Hepatitis tests, psychological problems, and the received for the same.

This request will be in effect from the date signed to the above named recipient only. I am aware that I may cancel this request at any time in writing to: Office Manager, 8401 University Executive Park Drive, Suite 123, Charlotte, NC, 28262.

_____ _____

Patient or Guardian Signature Date

Medical Record Request

Patient Name (printed) _____

Date of Birth _____

I authorize release of records from: _____

FAX: _____ PHONE: _____

Please release my medical records including:

- ☐ Progress Notes _____
- ☐ History and Physicals
- ☐ Lab Flowsheets
- ☐ Pathology _____
- ☐ Radiology _____
- ☐ Labs _____
- ☐ Medication logs/lists
- ☐ EKG _____
- ☐ Cardio-pulmonary reports
- ☐ Hospital discharge summary
- ☐ Renal Ultrasound _____
- ☐ Entire Record

☐ Other _____

Please fax/send records to:

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Patient or Guardian Signature Date