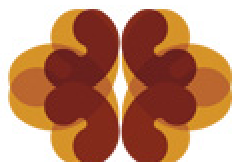

MIDTOWN ATLANTA NEPHROLOGY, P.C.
550 PEACHTREE STREET NORTH EAST, SUITE 1650, ATLANTA, GEORGIA 30308
Ph # 404-523-8810 Fax 404-523-8840

I, ____, authorize and request
First Name MI Last Name

____ to release M.A.N., PC a complete
Name of Provider/Facility

copy of the medical records of ____
Name of Patient

Date of Birth_______________________, Social Security Number_____________________

From___________________________________ to ________________________________

Reason for disclosure is____

I am aware that some of the health care information or other information contained in the requested medical records may be confidential or privileged, and I hereby specifically alive any privileges or confidentiality existing under the federal or state law regarding such information including but not limited to protection afforded to:

1. **AIDS confidential information**
2. **Medical information concerning alcohol and drug abuse**
3. **Medical information regarding mental illness**
4. **Medical information regarding mental retardation**
5. **Communication with Psychiatrists**
6. **Communication made to licensed applied Psychologists**
7. **Medical information concerning alcohol and drug dependence**

This authorization and consent is subject to revocation at any time, except to the extent that action has already been taken in reliance on it. If not previously revoked, this authorization will terminate 90 days from the date appearing below.

Date____ **Signature**___________________________________

Witness____ **Title**_______________________________________

This information was released to____

On____ **by**____

Kidney Care Excellence with a Warm Personal Touch