The Centers for Kidney Care

MEDICAL RECORDS RELEASE

I, _____, give permission to _____

_____ to disclose and deliver any and all medical information contained in my medical records, including HIV test results to:

_____ 1133 Medical Drive
Tyler, TX 75701
Phone: (903) 595-5486
Fax: (903) 595-5128

_____ 635 Stone Avenue
Paris, TX 75460
Phone: (903) 785-3300
Fax: (903) 785-3310

Such information disclosed or delivered may include the complete case history, copy of medical records and other information related to my treatment.

Specific information requested:

_____

_____

_____

_____ _____
Signature of Patient or Legal Guardian Witness

_____ _____
Date Date

Date Information Sent: _____