Northern Nephrology
52 Tom Miller Road
Plattsburgh, NY 12901
518-324-4000

Authorization for the release of confidential medical information

Patient Identification: **Name: _____**

Date of Birth: _____

Period of Time: _____ To _____

Reason for the release: _____ Medical Information **_____**

_____

Release of information to/from: _____

_____

_____

I authorize Northern Nephrology to (circle one) OBTAIN / RELEASE. medical records, x-ray reports, and other information regarding the hospitalization, and/or outpatient care concerning the above named patient for the period specified. I understand that this authorization will automatically expire in 6 months from the date below; unless otherwise specified. Time during which release is authorized: From: _____ To: _____.

_____ **_____**

Signature of patient or authorized representative **Date**

_____

Relationship to patient

_____ **_____**

Witness **Verification of Identification**

This information was release by _____ on _____ (date).