FORTWORTH RENAL GROUP

DAPO AFOLABI, MD
SAMATHA CHANDUPATLA, MD
GEETHANJALI RAMAMURTHY, MD

RELEASE OF MEDICAL INFORMATION

Patient Name:_________________________________ Date of Birth:____________________________

Social Security #:_________________________Patients Phone #:_______________________________

I request and authorize: FORT WORTH RENAL GROUP

To release the medical record of the above named patient to:

Name of recipient: ____

Address: ____

City and State: _______________________________________ Zip Code: ________________________

Telephone number: __________________________ Fax number: _______________________________

Reason for Release: ____

This request and authorization applies to: (check appropriate line)

_____Healthcare information relating to the following treatment, condition, or dates of treatment: ____ -Please send Facesheet, H&P, Consultation notes, Discharge Summary, Laboratory results, and Radiology reports.

_____All healthcare information including information relating to HIV/AIDS testing, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use.

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711 Pennsylvania Ave.
Ft. Worth, TX 76104
Phone: 682-207-1700

FORTWORTH RENAL GROUP | 711 Pennsylvania Avenue | Fort Worth 76104 |
Phone : (682) 207-1700 | Fax : : 682-499-6930

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Signature of patient or authorized representative Date

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative)

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