SIGNATURE
KIDNEY CARE

2001 N. MacArthur Blvd. Suite 335
Irving, TX. 75061
Tel: (214) 716 – 7573 Fax: (888) 657 - 4737

Name: _____ Date of Birth: _____

RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:

I understand it is important that clinicians have access to my medical records to help them safely treat me and manage my medical care.

I agree and understand that a copy of my medical records, including AIDS, HIV, behavioral health service, psychiatric care and treatment for alcohol or drug use, will be included as part of my health information.

I also agree that Signature Kidney Care PLLC can release my medical records to accrediting or regulatory agencies if those agencies request my records, and if the law allows those agencies to see my records. (Records are automatically sent to your referring doctor.)

RELEASE OF MEDICAL RECORDS FOR MEDICAL OR SCIENTIFIC RESEARCH:

Medical records may be reviewed to answer questions about how your care was delivered, the quality of care received or to identify your eligibility for a medical research study.

It also means your provider may contact you about your interest in a study. No personally identifiable information will be shared with outside parties without your written consent. This consent does not affect your treatment in any way.

This consent will remain in place unless withdrawn in writing.

Signature of Patient _____ Date: _____
Print Name: _____

Signature of guardian if needed _____