

Carroll County Nephrology, PC

157 Clinic Avenue, Suite 203

Carrollton, GA 30117

Phone: 770-832-0429

Fax: 770-838-9108

Authorization and Consent to Request, Release, or Transfer Medical Information

I, _____, authorize and request the release of my medical records.

I request that my records be released to/from **Carroll County Nephrology, PC**

This information may be mailed or faxed to the above medical practice.

Date of Birth: ___/___/_____ Social Security Number# _____-_____-_____

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

- AIDS Confidential Information
- Medical Information Concerning Alcohol and Drug Abuse
- Medical Information
- Medical Information Regarding Mental Illness
- Communications Made to Psychiatrist

This Authorization and Consent is subject to renovation 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 in 120 days from the date below.

Signature: _____ Date: _____

Witness: _____ Date: _____