Aurora Kidney LLC

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AUTHORIZATION TO DISCLOSE THE HEALTH INFORMATION OF:

Patient Name:_____

Parent/ Legal Guardian Name: _____
My legal ward, whose name is: _____

Patients:
Date of Birth:_____ Social Security # _____
Phone Number:_____ Fax Number:_____
Address: _____

THIS AUTHORIZATION IS TO DISCLOSE INFORMATION TO:

Name: _____
Address: _____
_____

Received By:
☐ Mail Address _____

☐ Fax Fax Number _____

☐ Pick Up Phone Number _____

PLEASE SEND THE INFORMATION AS INDICATED BELOW:

____ Diagnosis/ Procedure ____ Discharge Summary ____ Assessment/ Evaluation

____ Most Recent History ____ X-Ray Reports ____ Labs/ Lab Reports

____ Care Plan ____ Other (Please Specify): _____

Please check by each box that applies. An additional signature is required for any information regarding STD/HIV or Drug and Alcohol related information. Without a signature this information will not be released.

I consent to the release of information regarding STD/HIC or Drug and Alcohol Related information
Signature: Date: