The Kidney Group

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

_____

_____

I hereby request that my medical records be released to:

THE KIDNEY GROUP
2001 N.E. 48th Court, Suite 4-5
Fort Lauderdale, FL 33308

Telephone: (954) 771-3929 Fax: (954) 771-2393

PATIENT NAME:_____ D.O.B.: ____/____/____

SIGNATURE: _____ DATE: ____/____/____