REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____

From: _____
Name of Patient

Re: **Request for Release of Medical Records**

I hereby request that my medical records, without limitations, including any HIV test results and/or treatment and any psychiatric records, be released to:

Southern California Kidney Associates
1501 Superior Ave, Suite 205 Newport Beach, CA 92663

Phone: 949-642-4974

This authorization releases my medical records for the following designated purpose:

_____

This release is valid for 30 days after this date.

I understand that I am entitled to receive a copy of this release.

_____ _____
Signature of Patient or Legal Guardian | Patient's Date of Birth

_____ _____
Print Patient's Name | Date Signed

_____ _____
Print Name of Legal Guardian (relationship), if applicable | Witness