



**RECORDS RELEASE INFORMATION**

\_\_\_\_\_  
**DOCTOR AND/OR HOSPITAL**

\_\_\_\_\_  
**ADDRESS**

\_\_\_\_\_  
**CITY, STATE, ZIP**

I hereby authorize and request you to release to:  
Mid-Atlantic Nephrology Associates, P.A.  
XXX \_\_\_\_\_ Road Suite XXX  
XXXXX, MD XXXXX

Complete history of records in your possession, concerning my illness and/or treatment during the period from \_\_\_\_\_ to \_\_\_\_\_.

*This authorization shall expire no later than: \_\_\_\_/\_\_\_\_/\_\_\_\_ or upon the following event \_\_\_\_\_ (whichever is sooner), and may not be valid for greater than one year from the date of signature for Maryland medical records.*

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SS #: \_\_\_\_\_ DOB: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_