

FRESNO NEPHROLOGY MEDICAL GROUP, INC.

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Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

PATIENT: _____
Last Name First Name MI Date of Birth

ADDRESS: _____
Street City State Zip Code

MEDICAL RECORDS#: _____

MEDICAL RECORDS RELEASE: I understand that this authorization includes all medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, drug abuse and/or alcoholism, or Acquired Immuno-deficiency Syndrome (AIDS), or tests for infection with Human Immuno-deficiency virus (HIV).

- 1) I hereby give my authorization for FRESNO NEPHROLOGY MEDICAL GROUP, INC. (FNMG) to release medical records to other providers to the extent necessary to determine liability or eligibility for payments and benefits and to obtain reimbursement from insurance companies, health care service plans, workers' compensation carriers, and other state and federal health insurance agencies.
- 2) I hereby give my authorization for FNMG to send or request my medical records/labs to/from physicians and/or hospitals to which I am referred or have been treated by.
- 3) I hereby give my authorization for FNMG to verify my medical and pharmaceutical benefits for FNMG physician orders.
- 4) I hereby give my authorization for FNMG to request my lab and/or pharmacy history ordered by any physician.

This authorization may be revoked at any time upon my written request. A photocopy of this authorization is considered valid.

Further use or disclosure of the information being released beyond the specific limits of this consent is prohibited.

Signature of Patient or Authorized Person Relationship to Patient Date