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MEDICAL RELEASE AUTHORIZATION

I,_____, hereby authorize the physicians and/or staff of Pennsylvania Nephrology Associates, P.C. (PNA) to release medical information and/or records generated from PNA to my primary care doctor, other specialists and diagnostic facilities involved in my care, as needed. I recognize that the sharing of this confidential information is solely and necessary to facilitate my medical care.

_____ _____
Patient Signature Date

_____
Patient Date of Birth and Last 4 digits of SS#

_____ _____
Witness Signature Date