Texas Kidney INSTITUTE

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ ***Date of Birth:*** _____

I authorize _____to release health care information of the patient, named above to:

TEXAS KIDNEY INSTITUTE
Sumit Kumar, M.D.
Krishna Pakkivenkata, M.D.
Shaun Kaiser, M.D.
Surachit Kumar, M.D.
Office Number: 214 396 4950
Fax Number: 877 423 5360

☐ Copies of the complete history in your possession of my illness and/or treatment to include the following:

☐ Labs ☐ Procedures ☐ Other: _____

We will not disclose your medical information for any purpose except for treatment, payment, and health care operations. Any specific written authorization you provide may be revoked at any time in writing to Texas Kidney Institute. I am confirming my authorization for use and/or organizations named on this form.

_____

Patient Signature ***Date***

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative Name: _____

Personal Representative Signature: _____

Relationship to the Individual Patient: _____