NAMV NEPHROLOGY ASSOCIATES OF THE MERRIMACK VALLEY

DOUGLAS E. MESLER, MD
JOSEPH P. ROSSACCI, MD
ASHISH MAHAJAN, MD
NEERAJ JAIN, MD

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

1. I hereby authorize and consent to the release of the medical records obtained during my treatment at:

_____

For the time period of: _____ to _____

Furnish records to: _____

For the purpose of: _____

2. The specific information to be disclosed is:

☐ Encounter forms ☐ Operative Reports ☐ X-ray Reports

☐ Lab Reports ☐ History and Physical

☐ Other, specify: _____

3. If my initials appear here _____, I specifically authorize the release of drug, alcohol abuse, sexually transmitted disease and/or psychiatric records.
4. If my initials appear here _____, I specifically authorize release of my HIV test results for the purpose set forth above. My signature below indicated I have read this consent form, have asked all the questions I have about the reason for the release of my identity as a test subject and the results of my HIV test and I agree to the release of this information to the above-named party.
5. If my initials appear here _____, I specifically authorize release of my records that contain information about my diagnosis of or treatment of AIDS or ARC or contain some other reference to my identity as AIDS or ARC patient for the purpose set forth above.
6. I have carefully read and understand the above statements and do herein expressly and voluntarily consent to the disclosure of the above information about, or medical records of, my condition to those persons or agencies named above. **I hereby release Nephrology Associates of the Merrimack Valley from all liability that may arise from the release of these medical records.**
7. I understand that any person or organizations, to whom my records are disclosed, may re-enclose this information if legally mandated.
8. I understand this consent is subject to revocation at any time except to the extent action has been taken in reliance thereon. This authorization will expire 90 days from the date shown below unless otherwise stated here:

_____ _____

Signature of patient, responsible person, or parent if minor Date