Triangle Kidney Associates P.L.L.C
Medical Release Form

Patient's name _____

Date of birth ____ / ____ /_____

Social Security Number _____ - ____ - _____

Address _____
_____
_____
_____

Telephone number (____) ____ - _____

Please release my medical records to:

Triangle Kidney Associates P.L.L.C
400 Ashville Ave, Suite 315,
Cary, NC, 27518.
Phone: (919)803-3316
Fax.: (919)803-3354

From

Name of provider _____
Provider's address _____
_____
_____
_____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ Date: _____
Patient's Signature