REDWOOD RENAL
ASSOCIATES

Authorization to Release Medical Records	Today's Date:

When you complete and sign this form, you are authorizing health information about you to be shared with our office. We encourage you to request a copy of your records and review them before authorizing the release of records to someone other than yourself. Please clearly and legibly print all information when completing this form and sign and date below.

First Name:	Last Name:	Date of Birth:
Address:		
Social Security #	Best Phone #	

Authorization

I give my permission for you to speak with the following people regarding my health:

I hereby authorize the release of my Medical Information to Redwood Renal / Allen Mathew MD

This authorization is limited as follows:

Specifically ☐ _____

Any records requested ☐

Any Records except those relating to: Mental Health ☐ Drug & Alcohol ☐ HIV/AIDS ☐

This authorization becomes effective upon signing and expires:
Please note if not specified, we will honor this authorization for a 12 month period only

Signature of Patient:	Date:
Signature of responsible party if minor or under care:	Date:

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