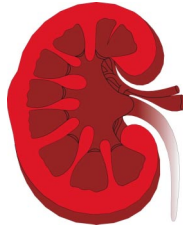


Edward D. Himot, M.D.
Indira Chervu, M.D., F.A.C.P.
Robert D. Jansen, M.D.
Akin O. Ogundipe, M.D., F.A.C.P.
Vijay Nath, M.D.
Sandeep Jaglan, M.D.



Georgia
Kidney
Associates

Amish N. Patel, M.D.
Renée Figueroa, ANP-BC
Paula Tucker, FNP-BC
Trang Nguyen, NP-C
Michele Chen, NP-C
Marietta Miller, Administrator

Nephrology • Hypertension • Internal Medicine

Authorization for Release of Medical Records

Patient Name: _____

Telephone: _____ **Date of Birth:** _____

Address: _____

I hereby authorize and request: _____

To furnish any and all information concerning my past and present medical history and condition to:

**GEORGIA KIDNEY ASSOCIATES, INC.
55 Whitcher Street, Suite 460
Marietta, GA 30060**

Or you may fax these records to: 770-427-1492

.....

Patient Signature: _____ **Date:** _____

(If patient is under the age of 18 years, parent or legal guardian must sign.)