Kidney Care Physicians, LLC
875 Oak St SE Suite #5070 Salem, OR 97301
Phone (503) 561-8565 Fax (503) 561-8560

Eva Lee MD Lance Dicker MD Andreea Andone MD Denis Privalov MD
Brett Mikeska MD Misha Mohindra MD Aneet Deo MD

CONSENT FOR RELEASE OF RECORDS

I, _____ DOB _____

Hereby Authorize: _____

Address: _____

To Release Pertinent records to: _____

For the purpose of: _____

Records requested (Patient please initial all pertinent lines):

Registration Information _____ Office Visits _____ Medication Information _____ History and Physical _____ Lab Results _____

Radiology Reports _____ Types of radiology reports requested _____

Special records requested (Patient please check boxes and sign):

☐ HIV Testing ☐ Psychiatric Notes Signature _____

Persons, other than the patient, may not disclose information contained in these records except as provided in ORS 179.505. I acknowledge that information to be released may **not** include Alcohol, Drug Abuse, and Psychiatric information without a special signature from the patient. My signature below authorizes release of requested information. I understand that I may revoke this permission, and that unless I revoke it earlier, it will expire in five years from the date below. To revoke this Authorization, I will send a written statement to Randall Boyer at 875 Oak St SE Suite 5070 Salem, OR 97301, indentifying the date I signed this Authorization and the information identified in this Authorization and state I am revoking this Authorization. I understand that any disclosures already made with my permission can not be taken back.

Signature: _____ ***Date:*** _____

FOR OFFICE USE ONLY

SENT VIA: ☐ FAX ☐ MAIL ☐ HAND CARRIED

Date Received: _____

Date Released: _____

Employee's Intials _____
