SOUTH SHORE NEPHROLOGY, P.C.
PIOTR LAZOWSKI, M.D.
PANAGIOTIS VLAGOPOULOS, M.D.

Authorization for Use and Disclosure of Health Information

Patient Name:_____
(please print)

Preferred Telephone Number(s):_____home
:_____cell

If I am referred to another physician by this office, I authorize the release of information necessary to the other physician's office and, in turn, I authorize their office to send my reports or results to this office. This authorization also applies to any Hospital or Clinic.

I authorize that my medical records can be faxed to another physician or hospital, if it is in my best interest.

I authorize that all test results and appointment information can be released to my spouse, partner or significant other.

I authorize messages, test results and appointment notices, etc. to be left on my answering machine if I cannot be reached personally.

I authorize the staff of South Shore Nephrology, PC to speak with the following individual(s) regarding my current care and treatment:

Name:_____Phone:_____

Relationship to Patient:_____

Name:_____Phone:_____

Relationship to Patient:_____

Patient Signature:_____Date:_____

Personal Representative Signature:_____

Relationship to Patient:_____