SOUTH SHORE NEPHROLOGY, P.C.
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RELEASE OF RECORDS

Date:_____

I,_____Date of Birth:_____
(print full name)

Patient Address:_____

_____
(city) (state) (zip code)

AUTHORIZE THE FOLLOWING:

Physician/Hospital_____

Address:_____

_____
(city) (state) (zip code)

Telephone:_____Fax:_____

TO TRANSFER THE FOLLOWING INFORMATION TO DR. PIOTR LAZOWSKI:

_____
_____
_____
_____
_____

Patient signature:_____Date:_____

If applicable, legal representative signature:_____Date:_____