

SOUTH SHORE NEPHROLOGY, PC
NEPHROLOGY – HYPERTENSION – INTERNAL MEDICINE
47 OBERY STREET, SUITE 1A PLYMOUTH, MA 02360
TEL: 508-747-4883 FAX: 508-747-6661

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. JOSE C. TEIXEIRA DA SILVA

Patient signature: _____ Date: _____

If applicable, legal representative signature: _____ Date: _____

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