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:_____
