

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. JOHANNA OREJO:

Patient signature: _____ Date: _____

If applicable, legal representative signature: _____ Date: _____

Confidentiality Notice: This fax communication and any attachments may contain confidential and privileged information for the use of the designated recipient named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify our office immediately at (508) 747-4883 and destroy all copies of this communication and any attachments. Thank You.