Medical Record Request

Date _____

Patient _____ DOB _____

Release Records From: _____

FAX: _____ PHONE: _____

Please release my medical records including:

- ☐ Progress Notes _____
- ☐ History and Physicals
- ☐ Lab Flowsheets
- ☐ Pathology _____
- ☐ Radiology _____
- ☐ Labs _____
- ☐ Medication logs/lists
- ☐ EKG _____
- ☐ Cardio-pulmonary reports
- ☐ Hospital discharge summary
- ☐ Renal Ultrasound _____
- ☐ Entire Record
- ☐ Other _____

Please fax/send records to:

Kathleen A. Doman, M.D.
Shalini Mundra, M.D.
Nephrology and Hypertension Consultants, P.A.
8430 University Executive Park Drive, Suite 685
Charlotte, North Carolina 28262
Phone: 704-503-4400 Fax: 704-503-4030

I understand that this authorization allows the release of my medical records including information concerning my chemical dependency, positive HIV, AIDS, and/or Hepatitis tests, psychological problems, and the received for the same.

This request will remain in effect until cancelled in writing. I am aware that I may cancel this request at any time in writing to: Practice Manager, 8430 University Executive Park Drive, Suite 685, Charlotte, NC, 28262.

_____ _____

Patient or Guardian Signature Date Signed

Release of Medical Information

Date _____

Patient _____ DOB _____

Records Release From:

Kathleen A. Doman, M.D.
Shalini Mundra, M.D.
Nephrology and Hypertension Consultants, P.A.
8430 University Executive Park Drive, Suite 685
Charlotte, North Carolina 28262
Phone: 704-503-4400 Fax: 704-503-4030

Records Released to: _____

Attn: _____ Record/Case Number: _____

Fax: _____ Phone: _____

I authorize the Release of the following records to the Company/Individual listed above.

☐ History and Physical _____ ☐ Medication List/Log

☐ Progress Notes _____ ☐ Pathology _____

☐ Hospital Discharge Summary _____ ☐ Radiology _____

☐ Consults _____ ☐ EKG _____

☐ Labs _____ ☐ Demographic/Billing Information

☐ Other: _____

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_____ _____

Patient or Guardian Signature Date Signed