William H. Cleveland, M.D
Michel D. Brathwaite, M.D.
Tanjela M. Jackson, M.D.
Evelyn C. Lewis, M.D.
Sammy M. Mugambi, M.D.

121 Linden Avenue Ste 102
Atlanta, Georgia 30331-3711
Tel: (404) 905-2828 Fax: (404) 905-2829

Patient:

Patient DOB:

Consent for Release of Information and Test Results

I, ____, give my consent and authorization to the staff of Atlanta Kidney Center to relay medical information to the following persons. This information may include but is not limited to scheduled appointments and/or surgeries, lab, radiology testing and medications.

Please check and complete the following:

Contacts: Phone: Relationship to patient:

____

____

____

____

OK to leave messages/fax:

YES **NO**

___ ___ Answering Machine at Home ___________________________

___ ___ Mobile Phone#______________________________________

___ ___ Fax Machine#_______________________________________

Date_____________ Signature____