

CONSENT TO RELEASE OF HEALTH INFORMATION

I, _____ (print name) of

_____ (print address)

hereby authorize and consent to the release by DIALYSIS MANAGEMENT CLINICS, INC. (DMCI) of all health information (including all health records) regarding the undersigned patient which are in the possession of DMCI, to the referring hospital _____, and its authorized physicians and staff for the purposes of providing care to the undersigned patient. I further authorize and consent to the release to the aforesaid information to other physicians and facilities as I may direct by couriers or telefacsimile.

I hereby release DMCI and each of its directors, officers, shareholders, employees and representatives from any and all claims whatsoever which may arise as a result of the release of the above noted information.

It is acknowledged and agreed that information will be released only after the undersigned patient or an authorized representative of the undersigned patient has paid DMCI any fees that may be deemed necessary for searching, photocopying and telefaxing.

Dated this _____ day of _____, 200__ .

Witness:

Signature

.....

NAME

DATE

.....

ADDRESS

.....

OCUPATION

Patient/Representative signature

Relationship to patient:

This authorization/consent will be valid while I am at DMCI unless revoked by myself or my representative.