Lawrence W. Klein, D.O., FACOI
Mark D. Oxman, D.O., FACOI
Barbara M. Doerr, PhD., D.O., FACOI
Jeffrey J. Kaufhold, M.D., FACP
Shashikant R. Patel, M.D.

Nephrology Associates of Dayton INC

Jennifer L. Jackson, D.O., FACOI
Chukwuma E. Eze, M.D.
Ashok K. Ammula, M.D.
Jennifer L. Munson, M.D.

Authorization for Release of Medical Information

I hereby grant permission to release the following records and/or information with no limitations, including any treatments for psychiatric illness, alcohol and drug abuse, to:

Nephrology Associates of Dayton, Inc.,
7700 Washington Village Drive, Suite 230
Dayton, Ohio 45459
Phone: (937) 438-3132
Fax: (937) 438-8707

Nephrology Associates of Dayton, Inc.
7231 Shull Road
Huber Heights, Ohio 45424
Phone: (937) 235-2757
Fax: (937) 235-2851

_____ Name of Patient

_____ Address of Patient

_____ Date of Birth

_____ Social Security Number

_____ Signature of Patient or Legal Representative

For Office Use Only:

Information Requested

- ☐ **Discharge Summary**
- ☐ **Final Diagnosis**
- ☐ **X-Ray Interpretation**
- ☐ **ER Report**
- ☐ **Renal Notes**
- ☐ **EKG Interpretation**
- ☐ **Laboratory Findings**
- ☐ **Nursing Notes**
- ☐ **Tissue / Biopsy Report**
- ☐ **Other**
- ☐ **History and Physical**
- ☐ **Operative Report**
- ☐ **X-Ray Films**
- ☐ **Renal Consult**

Remarks:_____

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