"Empowering through education"

Sandeep Munjal, MD
Nephrologist, Board Certified

Patient Name: ____

Date of Birth: ____________________ Social Security #: __________________________

I authorize the Physicians and/or Staff of Jacksonville Nephrology PA to obtain my medical records from:

Practice/Physician/Facility Name:_____________________________________

Address____

Phone_____________________________ Fax_____________________________

The following medical information regarding my care and/or treatment from:

Beginning date:_______________________ to ending date:_________________________

Information requested:

- ☐☐ All records
- ☐☐ Laboratory reports
- ☐☐ Imaging studies
- ☐☐ Reports/records from other physicians or facilities
- ☐☐ Pathology reports
- ☐☐ Progress notes
- ☐☐ Procedure reports

Purpose of Disclosure:

☐☐ Continuity of care ☐☐ Transfer of care ☐ ☐ Other (please specify)

_________________________________ _________________________

Signature of Patient or Representative Date

Relationship to Patient (if not patient)___________________________________

Please forward requested information to:

Jacksonville Nephrology
13241 Bartram Park Blvd, Unit 305, Jacksonville, FL 32258
Phone: 904-260-9898 **Fax: 904-260-9891**

Please respond by: