**Consent for Disclosure of Medical Records**

By signing this release, I authorize Dr. Matthew Mingrone to obtain my Protected Health Information from:

_______________________________________________________________________________

Name of organization to receive this Consent

This Consent permits Dr. Mingrone to obtain my medical records with your organization. Please fax my records to Dr. Mingrone at 408-800-4521

_________________________

Patient Name

_________________________

Date of Birth

_______________________________________________________________________________

Address

_______________________________________________________________________________

City State Zip

_______________________________________________________________________________

Patient Signature

_________________________

Date