Wichita Nephrology Group, P.A.

Professional Association
Nephrology Kidney and Hypertensive Disease

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RELEASE AND ASSIGNMENT **DATE**____________________

I hereby authorize **Wichita Nephrology Group, P.A.** to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care.

I authorize and request payment directly to the above named physician/group the amount due me in my pending claim for Medical and Surgical treatment or services, by reason of such treatment or services rendered to

__________________________________.
Patient Name (please print)

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature__________________________________

Address__________________________________

City & State__________________________________

R&A (1/09)