RENAL MEDICAL ASSOCIATES, P.C.

Patient Physician Care Team Information

Please list your General (family) Physician and any other physician(s) you would like to receive information from our practice in the spaces below:

General/Family Physician

Physician Name: ____________________ Phone Number: ____________

All Other Specialty Physicians:

1. Physician Name: ____________________ Specialty: ____________

   Phone Number: ____________

2. Physician Name: ____________________ Specialty: ____________

   Phone Number: ____________

3. Physician Name: ____________________ Specialty: ____________

   Phone Number: ____________

4. Physician Name: ____________________ Specialty: ____________

   Phone Number: ____________

I agree that information maybe sent to any of the listed physicians, and at any time I can notify Renal Medical Associates of any changes to restrict release of any health information.

____________________ ____________________

Patient Name (print) Patient Signature

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Date