

# Southeastern

Network 6



# Kidney Council, Inc.

## CMS 2728 Release Authorization

**\*Please allow 3 business days for processing your request.\***

I, \_\_\_\_\_, a patient at  
**Patient Name (Please Print)**

\_\_\_\_\_  
**Facility Name**

hereby give my permission for the Southeastern Kidney Council to release the following information for my medical record: **CMS Form 2728**

### To:

Facility Name: \_\_\_\_\_

Provider/Medicare Number: \_\_\_\_\_ (6 digit number)

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Phone No. \_\_\_\_\_

Facility Contact: \_\_\_\_\_

### Patient Information:

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Date**

*The mission of the Southeastern Kidney Council is to improve the lives of patients with or at risk for end stage renal disease by promoting and advancing quality of care.*