

**Southeastern Kidney Council, Inc.**

1000 Saint Albans Drive Suite 270

Raleigh, NC 27609

Phone: 919-855-0882

Fax: 919-855-0753

**CMS 2728 Release Authorization**

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: \_\_\_\_\_

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**