Richard G. Morgan, MD.
NEPHROLOGY

Date: Mr./ Ms. , ( )

Thank-you for choosing our office for your healthcare needs.

Enclosed are forms we will need for you to complete prior to your office visit with us. You may complete them at home and return to us or bring them with you to your appointment.

There may be enclosed a Request for Medical Records from your previous physician /s. We would appreciate you completing the form with as much physician contact information as possible and returning it with the enclosed self-addressed stamped envelope. We will attempt to obtain your medical records prior to your visit.

Also, a map is included for your convenience. We are located approximately 1 mile west (toward Downtown Bryan) of St. Joseph Hospital Emergency Department on 29 th. Street or 1 mile east of Texas Ave. We are between the intersections of Villa Maria and Coulter Ave.

Please bring **ALL** your medication bottles **OR** an up-to-date complete list to include the prescribing physician and correct dosages.

Please bring a copy or your original of any insurance cards you may have. If you have an insurance co-pay, by insurance policy contracts, we are required and therefore, we would like to collect your co-pay at the time of service, unless other prior arrangements have been made.

PLEASE NOTE: We accept cash and checks for co-pays and accounts payable. We have recently (2018) added PayPal MC/Visa, etc. w/ a 3% card fee and 4% digital entry fee, for your convenience.

We look forward to visiting with you. Call for directions, any problems or concerns

We do understand when patients need to reschedule. It would be appreciated if a 48 hour advanced notice is given so we may make adjustments to our schedule for other patients.

Sincerely,

Mary Morgan RN.

Office: 1705 East 29th Street Bryan, TX 77802	Telephone: (979) 775-9483 Fax: (979) 775-9557 Answering Service: (979) 361-5063	Solo private practice of Nephrology since July 11, 1977

RELEASE OF MEDICAL RECORDS

Authorization to release health care information.

Patient's name: _____

DOB:_____ SSN:/ **(LAST 4 DIGITS):**_____

I request and authorize: _____
to release the medical records of the patient named above to:

Name:___Richard G. Morgan, M.D._____ **FAX # # 979 775-9557**

Address:__1705 East 29th. Street_____ Telephone # 979 775-9483

City: _____Bryan_____ State:___Texas____ Zip Code: 77802

This request and authorization applies to: ____ Discharge Summary(s) _____

_____ All health care information ____ Other:_____

_____ Med. Records info for renal evaluations and treatments / H&P / medication list, all x-ray and lab reports

_____ Access to Electronic Medical Records at St-Joseph Regional Health Center, Bryan, Texas, College Station Medical Center - College Station, Texas and Baylor Scott & White Hospital and Clinic Records

I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall EXPIRE ONE-HUNDRED TWENTY DAYS after the date of the patient's signature below unless another date is specified (less than 120 days).

I understand any of the above requested information may include results of HUMAN IMMUNODEFICIENCY VIRUS (HIV) Tests, if any were performed.

I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological to prepare said documents.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from the records whose confidentiality is protected by Federal Regulation (42 CFR, Part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

X_____ X_____
Signature of patient or authorized representative Date Signed

X _____ Relationship _____

Printed Name and Relationship or Patient Status, if signed by any other person than Patient or Legal Guardian

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