

ESRD

NETWORK OF NEW ENGLAND, INC.

END STAGE RENAL DISEASE

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ATTN: Karen DeGeorge or Jaya Bhargava

Authorization to Release Medical Evidence Form 2728

Facility Name: _____ Provider No: _____

Phone: (_____) _____ Fax: (_____) _____

Date of the request: _____

Facility Staff: _____

I (*patient's name*) _____ give my permission to The ESRD Network of New England, Inc. to release my Form-2728 (Medical Evidence Form) to the above listed Dialysis \Transplant facility.

Social Security No: _____ D.O.B.: _____

Patient Signature: _____ Date: _____

Staff Witness: _____ Date: _____

Network of New England's Office Use Only

Date Received: _____ Date sent: _____

Network Staff: _____

Under contract with Centers for Medicare and Medicaid Services, The Network of New England, Inc. monitors the quality of care given to End Stage Renal Disease patients by providers of dialysis and transplantation. The information on this form will be used for intended purpose only and follows HIPAA guidelines.

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