



NORTHWEST RENAL NETWORK

4702 42ND Ave SW | Seattle, WA 98116 | PH: 206-923-0714 | FAX: 206-923-0716 |

Authorization to Release Medical Evidence Form 2728

To request a copy of a 2728 form, this release must be mailed or faxed to the Network. We do not accept requests through e-mail.

I (patient's name) _____ give my permission to the Northwest Renal Network to release my CMS Form-2728 (Medical Evidence Form) to the following facility:

∇ Dialysis/Transplant Facility Information

Provider Name: _____

CCN/Provider Number (6 digit number): _____

Fax Number: _____

Phone Number: _____

Signature of Patient /Legal Guardian: _____ **Date:** _____

(By signing, I authorize the Northwest Renal Network to release a copy of my 2728 form to the provider listed above)

Staff Witness (Print) _____

Staff Witness Signature: _____ **Date:** _____

(By signing, I have verified the identity of the person signing above is that of the patient or Legal Guardian)

∇ Patient Information

Patient Name: _____

Patient SSN: _____

Patient Date of Birth: _____

Network 16 Internal Use Only

Date Request Received: _____ Date/Time 2728 Form Sent: _____

Format: (Circle One) Fax Mail Date/Time 2728 Receipt Verified _____