# Nephrology Hypertension Associates
# of Central Jersey, P.A.

I hereby authorize Nephrology Hypertension Associates of Central Jersey to contact in the event of an emergency or release my medical information to the following person(s).

1. ______________________________________________

   Phone ________________________________________

   Relationship to patient______________________________

2. ______________________________________________

   Phone ________________________________________

   Relationship to patient______________________________

Patient name (print) _________________________________

Patient signature____________________________________

Date ____________________________________________