2770 North Webb Road Wichita, KS 67226 316-634-0090

Authorization Form for Release of Protected Health Information

I hereby authorize ____ to disclose my protected health information
Clinic

as described below to the person or organization listed below. I understand this authorization is voluntary.

I understand that if the person or organization listed below is not a health care plan or provider, federal privacy laws may no longer protect the released information.

I understand I may revoke this authorization at any time, unless the information has already been disclosed pursuant to a valid authorization and before I have withdrawn my authorization.

I may revoke the authorization at any time by sending a written request for revocation to:

____
Name

____
Title

____
Clinic

Information to be released (description, specific): ____

____

Date of authorization: ________________________

Date when authorization is revoked (if applicable): ________________________

Information may be released to: ____
Name/Organization

____
Address

____

____ ___________________________________
Signature of Patient or Patient's Representative Patient's Name, Address, DOB

____
Printed Name

____
Relationship to Patient