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

Authorization Form for Release of Protected Health Information

I hereby authorize *Kansas Surgery & Recovery Center* to disclose my protected health information
Hospital
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at any time, unless the information has already been disclosed pursuant to a valid authorization and before I have withdrawn my authorization.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:

Medical Records Release
Kansas Surgery & Recovery Center
2770 North Webb Road Wichita, KS 67226

Information to be released (description, specific): _____
_____
_____

Release Format: ___ Paper Copy ___ Electronic Media (CD)

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 | Telephone Number

_____ _____
Relationship to Patient | Last four digits of Social Security Number