Kansas Heart Office Plaza
9350 E. 35th St. N. ◦ Suite 101
Wichita, KS 67226

CARDIOVASCULAR CONSULTANTS OF KANSAS, P.A.

Office: 316-265-1308
In Kansas: 1-800-362-1093
Fax: 316-265-4480

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, born _____, consent to and authorize
(Patient Name) (Date of Birth)

_____ to furnish to _____
(Hospital or Physician) (Person, Facility, or Company)

at _____
(Address of Person, Facility, or Company)

Method of Delivery (check applicable box):

- ☐ Pick up copies of the medical records in office.
- ☐ Copies to be mailed.
- ☐ Medical records to be faxed (for immediate patient care only), Fax #_____
- ☐ To view the Medical Record.

Information to be released:
The following records:_____
_____
_____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/ psychological condition, psychiatric/ mental health treatment, and /or HIV related conditions.

_____
(individual or personal reps. initials)

Purpose of the release:
These records are required for the following purpose: _____

This authorization expires on _____ or within 90 days of the date signed. A photostatic or fax copy of this authorization shall be considered effective and valid as the original.

By signing below, you consent to the use and disclosure of your protected health information by Cardiovascular Consultants of Kansas, P.A.; our staff, and our business associates to the above entity. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Privacy Practices.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I also understand that I may revoke this authorization at any time by signing a Revocation Form at Cardiovascular Consultants of Kansas, P.A. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

Signature: _____ Date: _____

Witness: _____ Date: _____

The information disclosed to you may be from records protected by Federal Confidentiality Rules (42 CFR part 2). The federal rule prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for release of medical information is not sufficient for this purpose.

Authorization completed by:

Name: _____ Date: _____
(name of staff member/ method of release)