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P: (316) 636-6100
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ **DOB:** _____ **SSN#:** _____

ADDRESS: _____

HOME PHONE: Other Phone # _____

PLEASE RELEASE RECORDS FROM:

FULL NAME OF FACILITY/DOCTOR: _____

ADDRESS: _____

PHONE NUMBER: _____ **FAX NUMBER:** _____

PLEASE RELEASE RECORDS TO:

FULL NAME OF RECIPIENT: Wichita Urology Group

ADDRESS: 2626 N Webb Rd, Wichita, KS 67226

PHONE NUMBER: (316)636-6100 **FAX NUMBER:** (316) 636-5813

INFORMATION TO BE RELEASED:

☐ **Progress notes** ☐ **X-rays** ☐ **Lab reports** ☐ **All medical records**

☐ **Specific information or dates (please specify)**

REASON FOR REQUEST: _____

PATIENT AUTHORIZATION:

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS and HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the person/organization listed above.

SIGNATURE: _____ **DATE:** _____

THIS AUTHORIZATION WILL EXPIRE 90 DAYS AFTER THE DATE SIGNED This authorization reflects the requirements of 45 CFR 164.508 (August 14, 2003).