

Ayham J. Farha, MD
George F. Zakharia, MD
Gregory F. Byrd, MD
Fadi N. Joudi, MD
Timothy A. Richardson, MD
Jeffrey S. Davis, MD
Kenneth E. Schmanke, MD



Philippe S. Nabbout, MD
J. Andrew Jensen, MD
Kahlil N. Saad, MD
Patrick A. Houghton, MD
Surendra B. Kolla, MD
Jordan S. Stiverson, MD

East Office:

2626 N. Webb Rd, Wichita, KS 67226
P: (316) 636-6100 F: (316) 636-5813
T: (800) 739-6870

West Office:

7570 W. 21st St. #1014A, Wichita, KS 67205
P: (316) 636-6100
T: (877) 421-0119

Alysha L. Saenger, Exec. Director

Legacy Medical Arts Office:

2077 N. Webb Rd, Wichita, KS 67206
P: (316) 636-6100
F: (316) 636-5813

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____ SSN#: _____

ADDRESS: _____

HOME PHONE: Other Phone # _____

PLEASE RELEASE RECORDS FROM:

FULL NAME OF FACILITY/DOCTOR: _____ Wichita Urology Group

ADDRESS: _____ 2626 N Webb Rd, Wichita, KS 67226

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

PLEASE RELEASE RECORDS TO:

FULL NAME OF RECIPIENT: _____

ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

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).