Authorization to Disclose Health Information Form

3460 N Rdige Rd Ste 140
Wichita, KS 67205
PH: 316-283-4330
Fax: 316-283-4340

Patient Name: **Date of Birth:**

Address: **Phone:**

1. I authorize the use or disclosure of the above named individual's health information as described b

2. The following individual or health provider is authorized to make the disclosure:

Name Phone:

Address Fax:

3. The type of information to be used or disclosed is as follows:

4. This health information may be used or disclosed to the following organization:

Name: Phone:

Address: Fax:

5: I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the address below. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Patient/Legal Represenative **Date:**