The Mid-Kansas Dermatology Clinic, P.A.
1861 N. Rock Road, Suite 310
Wichita, KS 67206
Phone: 316-612-1833
Fax: 316-612-2420

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

____ ____________
Name of Patient (please print) Date of birth

____ ____________
Street Address City State Zip Phone Number

____ ____________
Maiden Name or other Name used for records Clinic Use: ID #

I hereby authorize: (Please Print) To Release to: (Please Print)

_________________________________ _____________________________________

_________________________________ _____________________________________

_________________________________ _____________________________________

The following information from my records:

- ☐ Complete Health Record(s)____
- ☐ Other (please specify) ____

Covering the period from ______________________________to______________________________

I understand that this will include information relating to:

- Acquired Immunodeficiency Syndrome (Aids) or Human Immunodeficiency Syndrome (HIV) infection
- Psychiatric care
- Treatment for alcohol and/or drug abuse

If any, except as specifically stated here: ____

This information is to be disclosed for the purpose(s) of ______________________________________

Specify the date, extent or condition upon which this authorization expires__________________________

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Mid-Kansas Dermatology Clinic at the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in sixty days from date signed below.

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations,

____ ______________________________
Signature of Patient or Patient's Representative Date

____
Print Name of Patient's Representative

____
Relationship to Patient

____ ______________________________
Signature of Witness Date

Revised 1/26/05