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 authorize the person/entity below to release my records: To: (Fax Number or Address Required)

_____ _____

_____ _____

_____ _____

Including 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: ☐ Continuing Care Other (please specify)_____

This authorization expires in 60 days unless otherwise specified as follows: _____

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.

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 (Please provide proof of legal appointment if applicable)

_____
Relationship to Patient

Revised 1/14/19