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 following release of protected health information:

Release Information FROM:	**Release Information TO:**
☐ Mid-Kansas Dermatology Clinic	☐ Mid-Kansas Dermatology Clinic
☐ Specify Facility and Address, Fax, or E-mail (required) below	☐ Specify Facility and Address, Fax, or E-mail (required) below
______________________	______________________
______________________	______________________
______________________	______________________

Including the following information from my records:

☐ Complete Health Record(s) ☐ Labs only ☐ Pathology only

☐ Other (please specify) ______________________

Covering the period: ☐ All ☐ Other, 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

____
If Signed by a Representative, Print Name of Representative (Please provide proof of legal appointment if applicable)

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Relationship of Representative to Patient