Cypress Heart
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Wichita, KS 67226
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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, __/__/____, _____,
(Patient's Name) (DOB) (Address)

hereby authorize _____,
(Name and Address of agency or institution)

to disclose to _____

the following information from my records (**specify extent or nature of information to be disclosed;**

type of reports) _____

_____

_____

Specific dates of treatment _____ to _____

The purpose or need for such information is for _____

_____

Medical records are protected by Federal Regulation and Kansas Statutes and further disclosure is prohibited without the undersigned consent.

This authorization is subject to cancellation at any time, but would not apply to any information already released in good faith.

Specify the date, extent, or condition upon which this consent expires:

_____
(If left blank, expiration date is sixty (60) days after date entered below)

If applicable, disclosure made in conformity with this authorization shall be accompanied by a written statement regarding re-disclosure as provided for by Federal Regulation 42 CFR Part 2.

_____ _____
Signature of patient Date

_____ _____
Signature of parent, guardian or authorized representative Witness

MR#_____ (office use only)