Cypress Heart
9300 East 29th Steet North, Suite 310
Wichita, KS 67226
ph 316 858 9000 • fx 316 858 9005

PERMISSION TO DISCLOSE CONFIDENTIAL INFORMATION

I, ________________________________, ____________, ____
(Patient's name) (DOB) (Address)

hereby authorize Cypress Heart to disclose my medical records to:

Name	Relationship

OR

____ I do not wish to have my information released

(Note: Entire record may be released unless otherwise noted)

Medical records are protected by HIPAA, federal regulation and Kansas statutes, and further disclosure is prohibited without the consent of the undersigned.

This authorization is subject to cancellation at any time, but does not apply to any information already released in good faith. This notice shall remain in effect until changed or revoked in writing by the patient.

If applicable, disclosure made in conformity with this authorization shall be accompanied by a written statement regarding redisclosure 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)