CYPRESS HEART
9840 E 21st St N
Wichita, KS 67206
(P)316.858.9000 (F)316.858.9005 (TF)877.449.1560

PERMISSION TO DISCLOSE CONFIDENTIAL INFORMATION

I, _____, DOB:
Residing at: (address of patient) _____

hereby authorize Cypress Heart to disclose my medical records to:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you do not want your medical records released please say so here: _____
(*Note: entire record may be released unless otherwise noted*)

Medical records are protected by HIPPA, federal regulation and Kansas statutes, and further disclosure is prohibited without 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 Signature of Witness

_____ _____
Signature of parent, guardian or auth rep. Date