Pronab K. Sensarma, M.D., F.A.C.P., F.A.C.C., F.C.C.P.
Ahmad Qaddour, M.D., F.A.C.C.
Ashraf Jmeian, M.D.
Daniel Alvarez, D.O.
G. Whitney Reader, M.D.

9840 E. 21st St N.
Wichita, KS 67206
Ph 316-858-9000
Fax 316-858-9005 or 316-858-9006

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Name: _____

DOB: _____

I hereby authorize _____

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 HIPPA, federal regulation and Kansas statutes and further disclosure is prohibited without the undersigned consent.

This authorization is subject to cancellation at any time but does 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

Signature of Witness