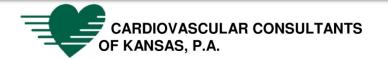
Kansas Heart Office Plaza 9350 E. 35th St. N. • Suite 101 Wichita, KS 67226



Office: 316-265-1308 In Kansas: 1-800-362-1093 Fax: 316-265-4480

AUTHORIZATION FOR RELEASE OF INFORMATION

I,		, born	, consent to and authorize
/	(Patient Name)	(Date of Birth)	, consent to and authorize
		to furnish to	
	(Hospital or Physician)	to runnish to	(Person, Facility, or Company)
at		(Address of Person, Facility, or Company)	
		(Address of Ferson, Facility, of Company)	
Metho	od of Delivery (check applicable box):		
	Pick up copies of the medical records	in office.	
	- · F		
		ediate patient care only), Fax #	
	To view the Medical Record.		
Inform	nation to be released:		
I autho	orize the release of any information conta	ained in the above records concerning tre-	atment of drug or alcohol abuse, drug-related
			treatment, and /or HIV related conditions.
(in divid	lual or personal reps. initials)		
(maivia	ual or personal reps. initials)		
Purpo	ose of the release:		
These	records are required for the following pu	ırpose:	
This a	uthorization expires on	or within 90 days of the date signed	d. A photostatic or fax copy of this
author	ization shall be considered effective and	valid as the original.	
By sig	rning below, you consent to the use and o	disclosure of your protected health inform	ation by Cardiovascular Consultants of
			led description of uses and disclosures for
	purposes, please review our Notice of Pr		r
. 1			
		nt to this authorization may be re-disclose	
		this authorization at any time by signing and that any such revocation does not apply	y to the extent that persons authorized to use of
	se my health information have already as		y to the extent that persons authorized to use t
uiscio	se my hearth information have affeatly at	act in renance on this authorization.	
Signat	rure:	Date: _	
Witne	ss:	Date:	
			ality Rules (42 CFR part 2). The federal rule
		ures of this information unless further dis-	
		s otherwise permitted by law. A general a	authorization for release of medical information
is not	sufficient for this purpose.		
Autho	orization completed by:		
Name		Date	_
ı tallıc.	(name of staff member/ method of release)	Bate	
- 1011101	: (name of staff member/ method of release)	Bac	