KANSAS GASTROENTEROLOGY

3121 N. Webb Road Wichita, Kansas 67226 Office: 316-261-3130 Fax: 316-261-3275

Authorization To Release Medical Information Form

Patient Name:_____ Date of Birth:_____

Address:_____ City, State, Zip:_____

To: ☐ From: ☐	To: ☐ From: ☐
Kansas Gastroenterology Name	_____ Name
3121 N. Webb Road Address	_____ Address
3162-261-3130 Phone	_____ Phone
316-261-3275 Fax	_____ Fax

☐ Abdominal Imaging ☐ Procedures ☐ Office Visits ☐ Other (Please Specify): _____

☐ Labs ☐ Pathology ☐ Hospital Records _____

Printed records over 10 pages released directly to patient will be a flat $25 processing fee. FMLA, disability, or other forms will be subject to a $30 processing fee per occurrence.

Patient Rights with Respect to this Authorization:

This authorization will expire on or upon the occurrence of_____ otherwise at 1 year from the date of my signature.

In signing this authorization, I understand and acknowledge the following:

- I understand that this authorization is voluntary and that I may refuse to sign it.
- I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.
- I understand that I may revoke this authorization at any time by notifying Kansas Gastroenterology in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization. Any notice of termination must be sent to the Privacy Officer, 3121 N Webb Road, Wichita, KS 67226.
- I understand that, unless otherwise revoked, this authorization will expire upon the date or event set forth above.
- I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.
- I, the undersigned, do hereby swear that I am the above-mentioned patient or a legal representative of the above mentioned patient. I have read and understand the above information.

_____ _____

Signature of Patient/Legal Representative's Date

_____ _____

Printed Name of Legal Representative Description of Legal Representative's Relationship to Patient