THE WOMEN'S HEALTHCARE GROUP OBSTETRICS & GYNECOLOGY

CONSE	ENT FOR RELEASE OF	MEDICAL	INFORMATIO	N FROM OUR (OFFICE
PATIENT NAME_ADDRESS HOME PHONE_PREVIOUS / OTHER NAMES ((MAIDEN / MARRIED)	CITY	STATESSN	BIRTH DATEZIP	
I, THE UNDERSIGNED, HERE	BY AUTHORIZE;				
10600 QU	MEN'S HEALTHCARE GROUP C IVIRA ROAD, SUITE 200 C ND PARK, KANSAS 66215	OFFICE OFFICE FAX	913-541-0990 913-541-1452		
TO RELEASE MEDICAL IN	NFORMATION CONCERNING	G THE ABOVE	NAMED PATIENT	TO:	
(NAME AND TITLE OF PERSON OR OR	GANIZATION TO RELEASE INFORMATIO	N)			
ADDRESS	CITY	STATE		ZIPCODE	
PHONE NUMBER	F	AX NUMBER			
☐ Entire File ☐ Other Reason for the Request: ☐	do you need to have forward	Moving □ Insu	rance □ Continuati		Visit □ Last 3 Years □ □
alcohol abuse programs; informa are maintained separately; inform C.F.R. 164.508; 42 C.F.R. Part 2	e used or disclosed pursuant to this tion relating to diagnosis and treatm nation relating to HIV testing, HIV s ; K.S.A. 65-5601 et seq.; and K.S.A rwise included within the scope of the	nent of mental heal status, or AIDS. I status, of AIDS at 1565-6001 et seq.	th (such as depression), understand that such in	alcoholic or drug counse formation is subject to sp	eling session provided such notes secial protections pursuant to 45
*THIS AUTHORIZATION WILL A	UTOMATICALLY EXPIRE ONE YEAR	R FROM THE DATE	OF SIGNATURE EXCE		DAY OR MONTHS)
release which was made prior to	is authorization may be revoked in water my revocation in compliance with the medical records is not a health plantsed.	his authorization sl	nall not constitute a bre	ech of my rights to confi	dentiality. I also understand that
	Guardiant		Date		Signature of