West Wichita Family Physicians
8200 W Central Avenue #1
Wichita, KS 67212
Phone: 1-316-721-4544
Fax: 1-316-721-8307

Medical Record Release Authorization

Patient Name_____Maiden Name_____

Date of Birth_____Home Phone_____Cell/Work_____

Address_____City/State/Zip_____

Email Address: _____

A) I hereby authorize records FROM:

Name West Wichita Family Physicians, P.A.

Address 8200 W. Central Suite One

City/State/Zip Wichita, KS 67212

Phone# 316-721-4544 Fax# 316-721-8307

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone#_____FAX#_____

Date Range_____to_____

- ☐ Physician Office Notes
- ☐ Cardiology/EKG Reports
- ☐ Immunizations
- ☐ Lab/Path Reports
- ☐ Operative/Procedure Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other _____
- ☐ Minimum Necessary

C) For the purpose of:

- _____ Litigation
- _____ Disability
- _____ Insurance
- _____ Work Comp
- _____ Self/Personal Copy
- _____ Other
- _____ Transfer or Continuity of Care

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____**Subject to Fees

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

***PLEASE READ** Fee Information*:* **West Wichita Family Physicians** contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the medical record state fee structure as set forth in the state statue. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy.

PLEASE SEND RECORDS RELEASE TO THE ENTITY/PROVIDER YOU ARE REQUESTING RECORDS FROM.