AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
AND CANCELATION OF FUTURE APPOINTMENTS

Patient's Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

_____ Other Phone: _____

Email: _____

REQUESTING RECORDS FROM: _____
_____
_____
_____

MAIL OR FAX RECORDS TO: Trust Women Wichita, LLC
5107 E. Kellogg Dr
Wichita, Kansas 67218
Phone: (316) 260-6934
Fax: (316) 425-3451

Please release medical records pertaining to the following:

_____

Reason for requesting records:

_____

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I authorize the release of the above requested records, including those, which may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and/or alcohol use, or sexual history, and that the records be forwarded to the above name and address. I further authorize that these medical records may be faxed if necessary. I understand that I may revoke this authorization at any time, except to the extent that action based upon this authorization has already been taken. I have given my consent freely, voluntarily, and without coercion.

_____ _____ _____

Patient Signature (or parent/legal guardian if minor) | Relationship to Patient | Date