# Request for Release of Confidential Information

RELEASE TO (Name and Address):

________________________________________

________________________________________

________________________________________

Please release the following information:

- ☐ Entire record
- ☐ Lab results
- ☐ Physician progress notes
- ☐ Other specific information: ________________________

For the following date(s) of service: ________________________

*Please Note: A processing fee of $25 will be assessed for any record over 50 pages. It is the responsibility of the patient to make arrangements for the payment of this fee before processing.

For the following purpose(s):

- ☐ Medical Evaluation and/or Treatment
- ☐ Other (please specify): ____________________

This authorization is valid for a period of six (6) months from the date of completion unless a different time period is specified. You may revoke this authorization in writing at any time.

____________________________ ______________
Printed Name of Patient — Date of Birth

____________________________ ______________
Signature of Patient, Next of Kin, or Legal Guardian — Date

____________________________
Witness

PROHIBITION OF RE DISCLOSURE: This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal regulation (42 CFR Part 2) prohibits you from disclosing this information further except with the specific written consent of the person to whom it pertains.

**How to submit your form**:
**By Mail**: Mail the form to Medical Records, and keep a copy for yourself
Medical Records, c/o Riordan Clinic 3100 N Hillside, Wichita, KS 67219
**Email**: Send the form to medicalrecords@riordanclinic.org
**Fax**: Send the form c/o Medical Records to 316-618-8537

WICHITA
316-682-3100
3100 N Hillside Ave
Wichita, KS 67219

OVERLAND PARK
913-745-4757
6300 W 143rd Street, Suite #205
Overland Park, KS 66223

1-800-447-7276