REQUEST TO OBTAIN CONFIDENTIAL INFORMATION

FROM: Enter the information for the health care provider whose records you would like sent to the Riordan Clinic:

Provider's Name: ______________________________

Clinic Name: ______________________________

Address: ______________________________

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Phone Number: ______________________________

Fax Number: ______________________________

TO: Riordan Clinic

☐	**Wichita:**	3100 N Hillside Avenue, Wichita, KS 67219	Medical Records FAX: 316.618.8537
☐	**Hays:**	1010 E 17th Street, Hays, KS 67601	FAX: 785.628.8341
☐	**Overland Park:**	6300 W 143rd Street, Suite 205, Overland Park, KS 66223	FAX: 913.745.5105

Please release the following information:

☐ Please send the following specific information: laboratory and imaging records for the last twelve months

☐ Other: ______________________________

For the following purpose:

☐ Medical evaluation and/or treatment

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

PATIENT'S NAME (PLEASE PRINT)	DATE OF BIRTH
SIGNATURE OF PATIENT OR GUARDIAN	**TODAY'S DATE**
WITNESS	

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

PLEASE CALL 316.682.3100 x300 IF FAXING MORE THAN TEN (10) PAGES.