REQUEST TO
OBTAIN CONFIDENTIAL INFORMATION

FROM: (Enter the name and address of your health care provider whose records you would like sent to the Riordan Clinic - The Olive W. Garvey Center for Healing Arts)

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TO: ***Riordan Clinic - The Olive W. Garvey Center for Healing Arts***
3100 N Hillside
Wichita, KS 67219
FAX (316) 618-8537

Please release the following information:

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

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 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 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 ext. 300 if faxing more than 10 pages

Riordan Clinic, 3100 N. Hillside, Wichita, KS 67219