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):

_____

_____

_____

TO: Riordan Clinic (The Olive W. Garvey Center for Healing Arts)
3100 N Hillside Avenue
Wichita, KS 67219
Medical Records FAX: 316.618.8537

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.