



**Cypress Heart**

**9300 East 29th Steet North, Suite 310**

**Wichita, KS 67226**

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**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, \_\_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_\_,  
(Patient's Name) (DOB) (Address)

hereby authorize \_\_\_\_\_,  
(Name and Address of agency or institution)

to disclose to \_\_\_\_\_

the following information from my records (**specify extent or nature of information to be disclosed;**

**type of reports**) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specific dates of treatment \_\_\_\_\_ to \_\_\_\_\_

The purpose or need for such information is for \_\_\_\_\_

\_\_\_\_\_

**Medical records are protected by Federal Regulation and Kansas Statutes and further disclosure is prohibited without the undersigned consent.**

**This authorization is subject to cancellation at any time, but would not apply to any information already released in good faith.**

Specify the date, extent, or condition upon which this consent expires:

\_\_\_\_\_

(If left blank, expiration date is sixty (60) days after date entered below)

If applicable, disclosure made in conformity with this authorization shall be accompanied by a written statement regarding re-disclosure as provided for by Federal Regulation 42 CFR Part 2.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Parent, Guardian, or Authorized Representative