AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ , DOB _____ , hereby authorize

_____

(name of agency, program, or individual and title)

to disclose the following information from my records (specify extent or nature of Information to be disclosed.)

_____

_____

The purpose or need for such disclosure is _____

_____

Medical records are protected by Federal Regulations, Kansas Statutes and/or Administrative Regulations and any further disclosure is prohibited without the undersigned's consent.

This authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

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

_____

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

If applicable, disclosure made pursuant to this authorization shall be accompanied by a written statement regarding re-disclosure as provided for by Federal Regulation 42C.F.F. Part 2.

_____ _____

Date Signed

_____ _____

Witness Parent or Legal Guardian Signature