Sunflower Medical Group

Family Medicine Internal Medicine Pediatrics Gynecology

2040 Hutton Road, Suite 102, Kansas City, KS 66109
913-299-3700 Fax: 913-721-3316

Authorization for Release of Information

Patient Name: _____ DOB: _____

Address: _____

Phone #: _____ Maiden Name: _____

I Hereby Authorize: _____
Physician, Clinic, or Hospital

Address: _____

Phone #: _____ Fax #: _____

To Release To: _____
Name of receiving Clinic

Address: _____

Phone #: _____ Fax #: _____

Release the following: _____ Records from Dr(s): _____

_____ All records

_____ Partial record (please specify)

_____ Other: _____

For the Purpose of: _____

This authorization shall remain valid until _____ or for 1 (one) year from the date of execution, whichever occurs first. My consent is subject to revocation in writing at any time except to the extent that action has already been taken by the releasing facility in reliance upon this consent.

Date: _____

Patient Signature: _____

Signature of Guardian: _____

Relationship to Patient: _____

Any further use or disclosure of the information by the person or organization requesting it is not authorized unless an additional consent is obtained or if permitted by law.
Any costs incurred in our obtaining previous medical records will be the responsibility of the patient.