Wichita Endocrinology, LLC

1515 S. Clifton, Suite 103
Wichita, KS 67218

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone: ( )_____

I hereby authorize the request of medical records from: Physician/Clinic/Hospital:

Address: _____

Phone: ( )_____ Fax: ( )_____

Reason for request: _____

To be released to: Physician/Clinic/Hospital:

Address: 1515 S. Clifton, Suite 103, Wichita, KS 67218

Phone: (316) 777- 6404 Fax: (316) 777- 6600

Please release the following information:

☐ Immunization records	☒ Growth charts	☒ Lab test results
☒ Progress notes (most recent)	☐ Cardiac studies	☐ Consultation reports
☐ Medical summary (if any)	☐ Imaging/radiology reports	

☐ Other: _____

_____

Signature of parent/guardian Date

_____

Printed name of parent/guardian Relationship to patient