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Authorization for the Release of the Medical Records of:

Patient Name _____

Date of Birth

Address _____

City, State, Zip

I, _____, hereby authorize and request that _____ **(NAME OF HEALTH CARE PROVIDER)**, release to Harris Health and Wellness, LLC, the medical records of the above-named patient, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans **from 1/1/2021-10/1/2025**. I understand that this authorization will expire when this request is fulfilled and that it may be revoked at any time in writing. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient or third parties and no longer protected by the HIPAA privacy rule.

I acknowledge that my records may include sensitive material. Therefore, I request that you include the following records, if any (initial by categories to be included in records provided):

☐ Substance Abuse
 ☐ AIDS/HIV/STDs
 ☐ Psychological/Psychiatric Conditions
 ☐ Genetic Testing

Please send the requested information to:

Phone: 785 453-8967

Fax: 785 301-1346

Harris Health and Wellness
901 Kentucky St. suite 108
Lawrence, KS 66044

Signature _____

Date _____

Relationship to patient: _____