Shana Roether FNP-BC
103 Smith Street
785-463-3333
milfordfp@gmail.com

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

SECTION I - PATIENT DATA

NAME (LAST, FIRST) DATE OF BIRTH (YYYYMMDD) SOCIAL SECURITY NUMBER

PERIOD OF TREATMENT: FROM - TO TYPE OF TREATMENT

SECTION 2 DISCLOSURE

I AUTHORIZE

a.TO RELEASE MY PATIENT INFORMATION TO:

Milford Family Practice

b. ADDRESS (Street, City, State and ZIP Code)

103 Smith Street Milford KS 66514

REASON FOR REQUEST

Continuity of care, change of PCP

AUTHORIZATION START

20210424

AUTHORIZATION EXPIRATION

SECTION 3 AUTHORIZATION

SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE DATE (YYYYMMDD)

Home Town Care for Home Town Families
Milford
Family Practice