Neurology Center of Wichita
220 S. Hillside
Wichita, KS 67211

Subhash Shah, MD.
Diplomat American Board of Pediatrics
American Board of Psychiatry and Neurology.

Kathryn Welch, PA-C

Judy Stanton, RN, BSN

Fax all medical records to
316-686-9797

For all medical records related questions call
316-686-6866 x 229

220 S Hillside

Wichita, KS 67211

Misc or Specific instructions

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_____
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This information has been disclosed to you from records whose confidentiality is protected by State & Federal Law. State & Federal regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information sufficient for this purpose.

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient: _____
Date of Birth_____/_____/_____

I hereby authorize: **Dr. Subhash Shah MD. and/or Kathryn Welch PA-C at Neurology Center of Wichita** *to* ***OBTAIN/EXCHANGE*** *all medical records including but not limited to EEG, Video EEG, Head ultrasound, CT, MRI, EMG/NCT, Labs, Consultations, Progress notes, Therapy notes, Educational records, Demographics and Insurance Information with:*

- **Physician/PA/ARNP** _____
- **Phone** _____ **Fax** _____
- **Psychologist/Psychiatrist**_____
- **Phone** _____ **Fax** _____
- **Physical Therapist** _____
- **Phone** _____ **Fax** _____
- **Hospital/Facility** _____
- **Phone** _____ **Fax** _____
- **School** _____
- **Phone** _____ **Fax** _____
- **Case Manager** _____
- **Phone** _____ **Fax** _____
- **Attorney** _____
- **Phone** _____ **Fax** _____
- **Self/Parent/Guardian** _____
- **Phone** _____ **Fax** _____
- **Other** _____
- **Phone** _____ **Fax** _____

X_____ **Date** _____/_____/_____

SIGNATURE of the Parent/Guardian/Patient

_____ _____

Printed name **Relationship to Patient**

This authorization will expire one year from signing date unless revoked sooner