PERMISSION TO GIVE MEDICAL INFORMATION

I, ____ hereby authorize the physicians and staff of Family Physicians of Kansas, LLC, to give the following people information concerning my health and well being.

_____ Spouse Name: ____________________________________

Telephone number ___________ Alternate telephone number _________

_____ Any other designated person

Name: ____________________________________Relationship ______________

Telephone number ___________ Alternate telephone number ______________

_____ Any other designated person

Name: ____________________________________Relationship ______________

Telephone number ___________ Alternate telephone number ______________

____ I do not wish for my medical information to be shared with anyone.

The following information may be given to the above individuals:

_____ Appointment Time

_____ Test/Lab Results

_____ Medications

_____ Procedures

_____ Any other information regarding my health

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure. This authorization expires upon written notification from the patient to alter the document

Print Name ____

Signed: ____ Date: _____________

(patient/parent/legal guardian)