AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Assem Z. Farhat, M.D. Husam Bakdash, M.D. Venkata Boppana, M.D.
Hussam Farhoud, M.D. Shilpa Kshatriya, M.D. Abid K. Mallick, M.D.
Wassim Shaheen, M.D. Ghiyath Tabbal, M.D. Saad Z. Farhat, M.D.
Ryan Beard, M.D. Yazan Alkawaleet, M.D. Maheedhar Gedela, M.D.

Medical Records:
Phone 316-686-5300
Fax: 316-651-2660

APP Providers: Erica Combs, APRN-BC; Ayman Hamad, APRN-BC; Kathy Nunez, PA-C; Darine Jamaleddine, APRN-BC; Lisa Gorges, APRN-BC; Ciera Briggs, APRN-BC; Mary Anne Warden, APRN-BC; Mary Medina, APRN-BC; Jessica Pollet, APRN-BC, Kim Long, APRN-BC

Please print the following information:

Patient: _____ Date of Birth: _____
Address: _____ Phone #: _____
City, State, Zip: _____ Other Name: _____

I hereby authorize Heartland Cardiology to provide my health information to:

Name: _____

Address: _____
City, State, Zip

Fax Number: _____

Which Records: _____

For the purpose of: _____

If for an appointment or surgery, what is the date? : _____

Specify the date, extent or condition upon which this authorization expires: _____

****

I understand that this authorization may be revoked at any time, except to the extent that action has been taken in accordance with this authorization. Unless otherwise specified, this authorization will expire 12 months from the date below. I understand and agree to pay a reasonable copying fee to cover the cost of this transfer.

I hereby release Heartland Cardiology and its personnel from all legal responsibility that may arise from the act I have authorized above. Heartland Cardiology is not responsible for completeness, legibility or omission caused by the copying of any medical records from another institution.

_____ _____
Signature of Patient Date Signature of Patient Representative Date

_____ _____
Printed Name of Patient Representative Relationship to Patient

Staff Initials: _____

Rev. 8/23