REQUEST AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Medical Records:
Phone 316-686-5300
Fax 316-651-8861

Physicians

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

APP Providers

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

Please print the following:

Patient: ____ Date of Birth: __________________

Address: ____ Phone #: ______________________

City, State, Zip: ____ Other Name: ___________________

I hereby authorize:

____

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____

To Release To:

Dr.: ______________________________________

Heartland Cardiology LLC
3535 N. Webb Road
Wichita, KS 67226
Fax to: 316-651-8861

The following information from my records:
_____ Complete Health Records
_____ Other (please specify): ____

This information is to be disclosed for the purpose of: ____

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

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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: __________