

VIS CLINIC

**REQUEST TO OBTAIN
CONFIDENTIAL PATIENT INFORMATION**

CLINIC OR DOCTOR TO REQUEST RECORDS FROM:

(Please provide the following information regarding your medical care provider whose records you would like sent to VIS CLINIC)

NAME OF CLINIC: _____
ADDRESS: _____
CITY AND STATE: _____
ZIP CODE: _____ **PHONE:** _____
FAX: _____

TO: VIS CLINIC
Chad Krier, ND, DC, Jennifer Mead, ND
4825 East Douglas Ave, Ste 100, Wichita, KS 67218
Phone (316) 425-3729
Fax (316) 425-3962

Please release the following information:

- Complete medical record
- Laboratory and imaging records
 - Previous twelve months Complete
- Doctor's notes
 - Previous twelve months Complete
- Medical Treatment
 - Complete Medication list Supplement list
 - IV and Injectable records

For the following purpose:

- Medical Evaluation and/or Treatment

PATIENT NOTICE:

This authorization is valid for a period of four months from today's date unless a different time period is specified. **You may revoke this authorization at any time in writing.**

Patient's Name (Printed)

Date of Birth

Signature of Patient or Guardian

Date

Witness

HIPPA REGULATIONS REGARDING PROHIBITION OF RE DISCLOSURE: This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of this Information except with the specific written consent of the person to whom it pertains.