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
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

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.