THE UNIVERSITY OF KANSAS CANCER CENTER 2330 Shawnee Mission Parkway Westwood, Kansas 66205

Do not write in this box



Medical Record #:	
Account #:	

AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION

(Patient Name),			born on		, hereb
authorize:					
2330 Shawne Westwood, K Attention:	y of Kansas Cancer C e Mission Parkway ansas 66205 (Contact Department)	Center —			
Contact Name:	·	Contact Phone	#		
□ C □ S	perative Reports linic Notes from pecific Dates only fro	□ Lab Tests □ Consultation Reports om:to .e., outside records, moni	☐ Radiolog	y/Therapy Reports Clinic (<i>This helps to i</i> c	
The purpose of this request is:	☐ Continued Car	re 🔲 Insurance/	Disability	☐ Litigation	
 I understand once the above Federal Privacy Laws. My treatment can not be c 					
 I understand that I may revany time except to the exte SPECIFICATION OF THE DATE, EVE 	voke this authorizatio nt that action has be	en taken in reliance on it.	-		zation as listed above a
	(In all cases this Aut	thorization will expire one	year from the	date below.)	
SIGNED THIS	DAY OF	F		, 20	
ID Verification of Requester (Drivers Lic	ense or Photo ID)		(Signature of	Patient OR AUTHORIZED F	REPRESENTATIVE)
(Witness – Office Staff Use Only)			(Nature of Rel	ationship)	
			(Address of Po	(Address of Person Signing Authorization)	
			City	State	Zip
			() Day Time Tele	phone -	