JOHN L'ECUYER, MD **JUDY K. MARTIN, MD**
RICHARD R. BREWINGTON, MD **RACHEL JAMES, APRN**

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Westwood, KS 66205

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby request that you:
(please print)

- ☐ John L'Ecuyer, MD
- ☐ Richard R. Brewington, MD
- ☐ Judy K. Martin, MD
- ☐ Rachel James, APRN

My health being at issue, please release my psychiatric records or speak directly to:

Party Being Sent to: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax Number: _____

Reason for releasing my records: ☐ Continuity of care
☐ (Be specific): _____

I understand that my medical records may include HIV, psychiatric, alcohol or drug abuse information. I also understand that I may revoke this consent by written request to this office at any time except to the extent that action already has been taken in reliance on it. This authorization expires automatically in one year. I understand that if the person or entity receiving this information is not a health plan or health care provider covered by federal privacy regulations the information used or disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state laws.
I understand that I may refuse to sign this authorization. My refusal does not affect my treatment, payment, or eligibility for benefits.

Signature of Patient: _____ Date: _____

Date of Birth: _____

Signature of Parent/Guardian (if applicable): _____

Witness: _____ Date: _____