Carolina Aponte Urdaneta, MD, LLC.
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Prairie Village, KS 66208
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AUTHORIZATION TO OBTAIN AND/ OR RELEASE PRIVATE HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS:

_____

I authorize and request Dr. Carolina Aponte Urdaneta to ☐ obtain from and ☐ release to:

NAME OF INDIVIDUAL, HOSPITAL OR AGENCY: _____

ADDRESS: _____

PHONE: _____

FAX: _____

Private health information including:

☐ Personal, ☐ Psychological, ☐ Psychometric, ☐ Educational, and ☐ Medical

Concerning the history, treatment, examinations and/or hospitalizations for the periods from _____ through _____

I understand that I may revoke this consent, in writing, at any time by informing any of the above noted individuals. This consent, unless revoked in writing, is in effect for one year from the date of signature.

I hereby release the above parties from any and all liability arising there from.

SIGNATURE OF PATIENT/ GUARDIAN: _____

_____

DATE: _____