



# ABAY NEUROSCIENCE CENTER

3223 N. WEBB RD., SUITE 1, WICHITA, KS 67226

PHONE 316-609-2600 FAX 316-609-2800

## MEDICAL RELEASE AUTHORIZATION

I, \_\_\_\_\_ authorize \_\_\_\_\_  
to release all information contained in my medical files to the Abay Neuroscience Center.  
This may include, but will not be limited to, the history of an injury or accident,  
subjective or objective complaints, interpretations of tests ordered in connection with  
treatment, description of treatment rendered, diagnosis and prognosis, further treatment  
deemed necessary, itemized statements of costs of treatment, notes and memos.

Please fax or mail the information needed to:

**Abay Neuroscience Center**  
**3223 N. Webb Rd., Suite 1**  
**Wichita, KS 67226**  
**Fax (316) 609-2800**

A photocopy of this authorization bears the same authority as the original.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian of Patient (if necessary)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date