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