Authorization for Release of Medical Information

Patient:

_____

Name of Patient | Former Name

_____

Date of Birth | Social Security #

By signing this authorization, I request and authorize all patient healthcare information to be released to Frontier Forensics Midwest.

Authorizing Party:

_____

Signature of Legal Next of Kin | Printed Name of Legal Next of Kin

_____

Relationship to Patient | Phone Number | Date

_____

Street Address | City | State | Zip Code

(To Be Completed by Frontier Forensics Midwest Personnel)

Authorizes information to be released by:	**Authorizes information to be sent to:**
_____ Name of Healthcare Provider/other	Frontier Forensics Midwest Name of Healthcare Provider/other
_____ Street Address	40 S 18th Street Street Address
_____ City, State, Zip Code	Kansas City, KS 66102 City, State, Zip Code
_____ Fax Number	913-912-1388 Fax Number

Requested Healthcare Information:

_____

_____

_____