

**Health Professionals of Winfield**

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**Information Release Consent Form**

I, \_\_\_\_\_, hereby authorize my information to be released to the following individuals, upon his/her request(s).

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_