



**Jane Murray, MD**  
*Family Medicine*  
**Cynthia Chamberlain, DiplAc, DiplCH**  
*Acupuncture & Chinese Medicine*  
**Mehdi Khosh, ND**  
*Naturopathic Medicine*  
**Tamara Coder Mikinski, PhD**  
*Licensed Psychologist*  
**Art Kent, NCTMB**  
*Natural Therapeutics*  
**William Hale, MD**  
*Psychiatry & Mind-Body Medicine*

**NAME:** \_\_\_\_\_

**(Maiden name):** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Medical Record #:** \_\_\_\_\_

**RECORDS REQUESTED FROM:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE DISCLOSE A COPY OF MY MEDICAL RECORD TO:**

**Sastun Center of Integrative Health Care**  
**10875 Grandview, Suite 2200**  
**Overland Park, KS 66210-1510**      **ATTN: Medical Records**

**Purpose of disclosure:**       **Request of the individual**       **Other \_\_\_\_\_(specify)**

**The following information is needed:**

\_\_\_\_\_  
 \_\_\_\_\_

I understand that my medical record may contain information regarding the diagnosis or treatment of HIV, other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it. By signing below, I give my specific authorization for any and all records, including those outlined above, to be released.

**THIS CONSENT EXPIRES IN ONE YEAR UNLESS OTHERWISE SPECIFIED.**

**DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_  
 (Patient)

\_\_\_\_\_  
 (Parent, Guardian, or Authorized Representative)

**WITNESS:** \_\_\_\_\_

Note: Revocation of this authorization needs to be made in writing, signed, dated and mailed to the Sastun Center of Integrative Healthcare, attn: Office Manager. A revocation of this request will not effect action already taken. A provider may not condition treatment based on you signing this form.