PATIENT RECORDS CUSTODIAN CONTACT INFORMATION

LICENSEE:

NAME: ____

ADDRESS: ____

PHONE NUMBER: ____

FAX NUMBER: ____

CUSTODIAN:

NAME: ____

ADDRESS: ____

PHONE NUMBER: ____

FAX NUMBER: ____

RECORDS:

PHYSICAL LOCATION: ____

PAPER OR ELECTRONIC: ____

DESTRUCTION DATE: ____

WERE PATIENTS NOTIFIED OF TERMINATION OF PRACTICE: ________________________________

OTHER: ____

____

Return to:
LeeAnn Hunter-Roach
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Kansas Board of Healing Arts
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Topeka, Kansas 66612
Leeann.hunter-roach@ks.gov
FAX: 785/296-7102