Bradley K. Harrison MD, FAAFP

Kyle E. Platz DO, FAAFP

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:**_____ **SS#:**_____

Patient Address:_____
Address City State Zip

I, the undersigned, hereby authorize disclosure of information FROM: Manhattan Primary Care
1133 College Ave. Ste A211
Manhattan, KS 66502

Obtain/Release the following written information:

□ Complete Health Record
□ Office Notes from _____ to _____ □ X-rays from _____ to _____
□ Lab from _____ to _____ □ Other _____ from _____ to _____
□ Verbal Communication of treatment and discuss relevant concerns.

Disclose Information To: _____
Physician / Clinic / Hospital Fax

_____
Address City State Zip

Purpose of Disclosure:

□ Consultation with _____ □ Transfer of Care □ Ins Coverage □ Personal Access

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of information related to:

Please check Yes or No (each MUST be specified, regardless of history)

□ Yes □ No Substance Abuse (Alcohol or Drug Information)
□ Yes □ No Mental Health Information
□ Yes □ No HIV Related Information (AIDS Related Testing)
□ Yes □ No Information Protected by State and Federal Laws Related to a Minor

Patient/Guardian or Legal Representative Signature:_____ **Date:**_____

In order for the above information to be released, you must sign here AND below

This authorization will expire on the following date or event: _____ unless otherwise revoked, Effective for no longer than one year from the date on which it was signed. I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Manhattan Primary Care, LLC. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under the appropriate conditions established by Manhattan Primary Care, LLC. The covered entity will not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization. The facility, its employees and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient/Guardian/Legal Representative Signature: _____ **Date:**_____

Relationship to Patient:_____