

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: \_\_\_\_\_  
Physician / Clinic / Hospital

\_\_\_\_\_  
Address / Fax / Phone

**Obtain/Release the following written information:**

- Office Notes from the last year, labs from the last 2 years, last physical, all consults, and all radiology.
- Complete Health Record  Verbal Communication of treatment and discuss relevant concerns.
- Office Notes from \_\_\_\_\_ to \_\_\_\_\_  X-rays from \_\_\_\_\_ to \_\_\_\_\_
- Lab from \_\_\_\_\_ to \_\_\_\_\_  Other \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

**Disclose Information To:** Manhattan Primary Care Fax: 888-524-2251  
 1133 College Ave Ste. A211 Phone: 785-320-5000  
 Manhattan, KS 66502

**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 or Legal Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

Manhattan Primary Care  
1133 College Ave, Suite A211; Manhattan, KS 66502-2770  
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