Manhattan Dermatology
1640 Charles Place, Suite 103
Manhattan, KS 66502
Phone: (785) 539-4645--Fax: (785) 539-1655

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

To be completed by the patient to authorize disclosure to self or others

_____ _____
Patient Name Date of Birth

_____ _____
Current Address Current Phone Number

I authorize the use or disclosure of the above named individual's health information as described below:

1. The following individual or organization is authorized to make the disclosure:

_____
Name

_____
Address

2. The type and amount of information to be used or disclosed is as follows: (check all that apply)

- ❑ Complete copy of medical record
- ❑ Pathology reports: ❑ All OR ❑ Date range from _____ to _____
- ❑ Lab reports: ❑ All OR ❑ Date range from _____ to _____
- ❑ All records within date range from _____ to _____
- ❑ Only records pertaining to _____

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual or organization:

_____
Name

_____
Address

5. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the address below. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Manhattan Dermatology, Byron B. Alexander, M.D., and David Harden , M.D., and Erin E. Thornton, PA-C, and Casey Jankord, PA-C, 1640 Charles Place, Suite 103, Manhattan, KS 66502

6. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

If I fail to specify an expiration date, event, or condition, this authorization will expire in six (6) months *from the date signed*.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

8. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

9. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules.

10. If I have questions about disclosure of my health information, I can contact the clinic's privacy officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Patient is entitled to a copy of this request

□Patient requested these records Delivery Method: □Fax □Mail