AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Stonecreek Family Physicians, LLP, 4101 Anderson Ave, Manhattan, KS 66503
Telephone: 785-587-4101 Fax: 785-587-9090

(Complete all spaces. Failure to do so may prevent or delay release of information)

Patient Name:_____Date of Birth:_____SS#:_____

Patient Address:_____
Address City State Zip

Disclosure of Information From: Stonecreek Family Physicians, OR

_____
Name Address City State Zip

Information to be Disclosed:

___ Office Notes from _____ to _____ ___ Other _____ from _____ to _____
___ Lab from _____ to _____ ___ Complete Health Record (Past 5 years unless specified otherwise)
___ X-rays from _____ to _____
___ Verbal communication of treatment and discuss relevant concerns

Disclose Information To: Stonecreek Family Physicians, OR _____

Physician / Clinic / Hospital

_____
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

___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 Stonecreek Family Physicians, LLP. 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 Stonecreek Family Physicians, LLP. 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:_____
Address City Zip Telephone #