

Instructions for completing the Authorization to Use or Disclose PHI:

1. Complete the top left Patient section with the requested patient's name, date of birth, and phone number.
2. Complete the top right Recipient section with the requesting recipient's name, mailing address, phone number, email address, and fax number (if applicable).
3. **Requested Dates of Service:** Please list specific dates. If you do not remember the specific dates, please indicate at least a time frame such as "last month," "last six months," etc.
4. **Authorization Expiration:** If a date is not marked/chosen, the request will expire after 180 days of initial receipt.
5. **Purpose of Disclosure:** Please mark if the records are for continuation of care, personal, insurance, or legal.
6. **Request Delivery:** Check the appropriate box. Paper records or CDs will be mailed to the address provided. Records can be sent via secure email if requested.
7. **Description of information to be disclosed:** Mark the appropriate box(s) for the documents that you are requesting. Please be specific.
8. **Read the acknowledgements and understandings:** Specify any information you want to exclude from the Authorization to Disclose PHI on the line in this section.
9. **Patient/Authorized Representative Signature:** This form should be signed by the patient. If the patient is unable to sign and the request is being made by an authorized representative of the patient (parent/guardian of a minor, Power of Attorney, executor of estate, etc.), the Authorized Representative should sign and date the form. Please provide printed name and relationship to the patient. *Supporting legal documentation must accompany this authorization form when signed by a personal representative.*
10. **A valid driver's license or photo ID will be required at the time of medical records pick up or any in person request for PHI.**

***Please contact Health Information Management at 785-776-2540 if you have any further questions.*

Manhattan Surgical Hospital – Health Information Management

Attach signed form and email to ROI@manhattansurgical.com or fax to **785-776-5101**

1829 College Ave, Manhattan KS 66502

www.manhattansurgical.com

PATIENT NAME:	RECIPIENT'S NAME:		
PATIENT'S PHONE:	RECIPIENT ADDRESS:		
PATIENT'S DATE OF BIRTH:	CITY:	STATE:	ZIP:
REQUESTED DATES OF SERVICE:	RECIPIENT'S PHONE NUMBER:		
	RECIPIENT'S FAX NUMBER :		
RECIPIENT'S EMAIL ADDRESS (FOR RELEASES TO EMAIL):			
THIS AUTHORIZATION WILL EXPIRE AFTER 180 DAYS OR ON THE FOLLOWING (PLEASE CHOOSE ONLY ONE): EXPIRATION DATE: OR EXPIRATION EVENT:	PURPOSE OF DISCLOSURE: <input type="radio"/> AT THE REQUEST OF INDIVIDUAL; OR <input type="radio"/> OTHER 3RD PARTY RECIPIENT (PLEASE SPECIFY PURPOSE):		
REQUEST DELIVERY: <input type="radio"/> PAPER COPY <input type="radio"/> ELECTRONIC MEDIA, IF AVAILABLE <input type="radio"/> ENCRYPTED EMAIL <input type="radio"/> UNENCRYPTED EMAIL <input type="radio"/> MAILED (ADDRESS ABOVE)			
<p>There is some level of risk that a third party could see your information without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email. Note: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).</p>			
DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED: <input type="radio"/> DISCHARGE SUMMARY <input type="radio"/> LAB/TEST RESULTS <input type="radio"/> IMAGING/RADIOLOGY REPORTS <input type="radio"/> NURSES' NOTES <input type="radio"/> PHYSICIAN ORDERS <input type="radio"/> BILLING RECORDS <input type="radio"/> HISTORY AND PHYSICIAL <input type="radio"/> OPERATIVE REPORT <input type="radio"/> PHYSICIAN PROGRESS NOTES <input type="radio"/> ENTIRE MEDICAL RECORD <input type="radio"/> OTHER: _____			
All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive, such as alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. Specify any information you want to exclude:			
I understand that: <ol style="list-style-type: none"> I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the recipient is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. 			
SIGNATURES: I have read the above and authorize the disclosure of the protected health information as stated.			
SIGNATURE OF PATIENT/PATIENT'S REPRESENTATIVE:			DATE:
PRINT NAME OF PATIENT'S REPRESENTATIVE:			Relationship to Patient: