



This form is only for HBC releasing of information to a patient or third party/medical facility

SECTION A: PATIENT INFORMATION:

Name: _____ Date of Birth ____/____/____
Address: _____ City _____ State _____ Zip _____
Social Security _____ - _____ - _____ Phone Number _____ MRN _____

SECTION B: HEALTH INFORMATION TO BE RELEASED:

I hereby authorize Hattiesburg Clinic, PA to DISCLOSE to [] Myself/Patient or [] Third Party/Medical Facility

Please complete Third Party/Medical facility contact information below:

Entity Name: _____
Provider's Name (if Entity is a medical facility): _____
Address: _____ City _____ State _____ Zip _____
Phone Number _____ Fax Number _____

SECTION C: INFORMATION TO BE RELEASED & PURPOSE:

Covering the period(s) of healthcare: From ____/____/____ to ____/____/____

Releasing (please check all that apply):

- [] Entire Chart [] Immunizations [] Lab Results/Pathology [] Medication List [] Office Visit [] Operative Report
[] Outpatient/ASC [] Radiology/Imaging/Studies [] Other (please be specific) _____

Purpose (please check one):

- [] Disability [] Insurance [] Legal/Attorney [] Medical Facility/Continuing Care [] Personal Use [] School [] Workers Comp
[] Other (please specify) _____

SECTION D: INFORMATION DISCLOSED BY:

Disclosed by: [] CD [] Fax [] Mail [] IRIS [] Patient Pick-Up OR [] Patient Designee to pick-up: _____

NOTE: If someone other than the patient is picking up records. The name must be listed and when they present for pick-up they must have I.D.

SECTION E: MENTAL HEALTH & SUBSTANCE ABUSE (PLEASE COMPLETE ONLY IF APPLICABLE):

For the release of psychotherapy notes, you must complete a separate authorization form

I specifically authorize the release of information relating to mental health and/or substance abuse records.
Covering the period(s) of healthcare: From ____/____/____ To ____/____/____
Signature of Patient or Legal Guardian _____ Date _____

SECTION F: PLEASE READ & INITIAL:

Table with 2 columns: Initials and numbered statements (1-5) regarding understanding of authorization terms.

SIGNATURE OF PATIENT _____ DATE _____ OR PARENT/LEGAL GUARDIAN/ AUTHORIZED PERSON _____ DATE _____
RELATIONSHIP TO PATIENT _____
My parental rights have not been terminated. (In the case of signing for a minor child)

WITNESS _____ DATE _____

Form with fields: COMPLETE, NEEDS COMPLETING, DATE FULFILLED, IDENTIFICATION PRESENTED, SATELLITE OFFICE, BY, JOB TITLE, EXT.