HATTIESBURG CLINIC

Authorization for Disclosure of Medical Information

Release of Information
415 South 28th Avenue
Hattiesburg, MS 39401
Phone: 601-579-5276
Fax: 601-268-5767

******This form is <u>only</u> 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/Parent or Guardian
Third Party/Entity or Parent 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:

Date(s) of healthcare: From _____/___/_____ to ____/___/_____

Releasing (please check all that apply):
□ Immunizations □ Lab Results/Pathology □ Medication List □ Office Visit □ Operative Report □ Outpatient/ASC
□ Radiology Report □ Radiology Images (separate CD) □ 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 □ EMAIL _____
□ Patient Pick-Up **OR** □ Patient Designee to pick- up: _____ Date of 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 <u>(PLEASE COMPLETE ONLY IF APPLICABLE):</u>

******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:

Initial _____	1. I understand that this authorization will expire in 90 days.
Initial _____	2. I understand that I may revoke this authorization at any time by notifying Hattiesburg Clinic, P.A. in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
Initial _____	3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulation (HIPAA).
Initial _____	4. I understand that I may see and copy the information described in this form if I ask for it, and I will get a copy of this form if I sign it.
Initial _____	5. I understand that this authorization is voluntary. If I do not sign this form, my healthcare from Hattiesburg Clinic and the payment for this healthcare will not be affected.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE 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

***** FOR HBC USE ONLY (PLEASE PRINT) *****

I assisted in the completion of this form with the patient present due to: _____ _____
(Details on why you assisted) *Print Name (same person as Witness)*

□ **COMPLETED (1-6)** □ **NEEDS COMPLETING (1-4)**

1. SATELLITE OFFICE: _____ 2. BY: _____ 3. JOB TITLE: _____
4. EXT: _____ 5. DATE FULFILLED: _____ 6. I DENTIFICATION PRESENTED: _____