HATTIESBURG CLINIC

Authorization to Obtain Medical Information
Outside Medical Facility

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

******This form is used only for records being requested from outside medical facilities to be received by HBC******

SECTION A: PATIENT INFORMATION:

Name: _____Date of Birth _____/_____/_____
Address: _____ City _____State _____Zip _____
Social Security _____-_____-_____ Phone Number _____MRN _____

SECTION B: STATEMENT OF AUTHORIZATION:

I hereby authorize Hattiesburg Clinic, PA to **OBTAIN from:**

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):

☐ Immunizations ☐ Lab Results/Pathology ☐ Medication List ☐ Office Visit ☐ Operative Report ☐ Outpatient/ASC
☐ Radiology Reports ☐ Radiology Images (separate CD) ☐ Other (please be specific) _____

Purpose (please check one): ☐ Medical Facility/Continuing Care ☐ Other (please specify) _____

SECTION D: DISCLOSE (please check one): ☐ Fax or ☐ Mail

To: Hattiesburg Clinic, PA

Provider's Name: _____
Department/Satellite Name_____
Address: _____ City _____State _____Zip _____
Phone Number_____ Fax Number _____

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

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 (1-3)** ☐ **NEEDS COMPLETING (1-4)**

1. SATELLITE OFFICE: _____ 2. BY: _____ 3. EXT: _____ 4. DATE COMPLETED:_____