

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 <u>only</u> for records being requested from outside medical facilities to be received by HBC

Name:				Date of	f Birth	/ /
Address:						
Social Security		Phone N	umber	MRN		r
CTION B: STATEMEN	T OF AUTHORIZ	ATION:				
hereby authorize Hattiesbu Entity Name	_					
Provider's N	ame (if Entity is a m	nedical facility):		State		
Phone Numb	per	Fa	x Number			
CTION C: INFORMATI						
Releasing (please che Immunizations	ck all that apply): Lab Results/Pathol	ogy Medicatio	n List Office Visit	Operative Report	•	ent/ASC
				e)		
Purpose (please check	•	-		specify)		
TION D: DISCLOSE (•	Fax or Mail				
To: Hattiesburg Cl Provider's Nan						
Department/Sa	tellite Name					
Address:			City	State	Zip	
CTION E: MENTAL HE	EALTH & SUBSTA	Fax N	Number	ONLY IF APPLICA		٦
I specifically author Covering the period	EALTH & SUBSTA	Fax Pance ABUSE (Please or mation relating to material from//	Number	ONLY IF APPLICA		
I specifically author Covering the period	EALTH & SUBSTA	Fax Pance ABUSE (Please or mation relating to material from//	Number	ONLY IF APPLICA		
I specifically author Covering the periods is	EALTH & SUBSTA	Fax Pance ABUSE (Please or mation relating to material from//	Number	ONLY IF APPLICANT ONLY IF APPLICANT OF APPLI		
I specifically author Covering the periods Signature PLEASE REA	EALTH & SUBSTA prize the release of info od(s) of healthcare: F enature of Patient or Lea AD & INITIAL:	Fax MANCE ABUSE (PI Department of the control of t	Number LEASE COMPLETE ental health and/or substa _ To//	ONLY IF APPLICANT ONLY IF APPLICANT OF APPLI		
I specifically author Covering the periods Sistematical 1. It is not at the control of the covering the periods are also as a second of the covering the periods are also as a second of the covering the periods are also as a second of the covering the covering the periods are also as a second of the covering the cove	EALTH & SUBSTA prize the release of info od(s) of healthcare: F enature of Patient or Le AD & INITIAL:	Fax MANCE ABUSE (PI Department of the Prom// Department of the Prom// Department of the Prom// Department of the Prom// Department of the Promotion of the	LEASE COMPLETE ental health and/or substa To// in 90 days.	ONLY IF APPLICANT nce abuse records. Date	BLE):	
I specifically author Covering the periods Signature PLEASE REAL Initial 1. It on	EALTH & SUBSTA prize the release of info od(s) of healthcare: F enature of Patient or Lea AD & INITIAL: understand that this autinderstand that I may re the date notified excep	Fax Mance ABUSE (Plantation relating to manager of the Prom//	LEASE COMPLETE ental health and/or substa To// in 90 days. ion at any time by notifyi has already been taken in	ONLY IF APPLICANT IN THE PROPERTY OF THE PROPE	A. in writing,	and it will be effective
I specifically author Covering the periods initial 1. I to on a control of the periods initial 2. I to on a control of the periods initial 3. I to low a control of the periods initial 3. I to low a control of the periods initial 3. I to low a control of the periods initial 3. I to low a control of the periods initial 3. I to low a control of the periods in the period in the periods in the periods in the periods in the period in the periods in the period in th	ealth & SUBSTA orize the release of info od(s) of healthcare: F enature of Patient or Lea AD & INITIAL: understand that this autinderstand that I may real the date notified excellent on the date notified excellent or the date of the thing of the thing.	Fax Mance ABUSE (Plantation relating to management of the properties of the properties of the properties of the extent action attion used or disclose deral privacy regulation.	in 90 days. ion at any time by notifyi has already been taken in d pursuant to this authorition (HIPAA).	ONLY IF APPLICATION ONLY IF APPLICATION ONLY IF APPLICATION ON THE PROPERTY OF	A. in writing,	and it will be effectively the recipient and n
TION E: MENTAL HE I specifically author Covering the period Signature TION F: PLEASE REA Initial	ealth & SUBSTA prize the release of info od(s) of healthcare: F enature of Patient or Le AD & INITIAL: understand that this aut understand that I may re the date notified except understand that informance be protected by Fo understand that I may see	Fax Mance ABUSE (Plantation relating to management of the property of the property of the extent action attion used or disclose ederal privacy regulative and copy the information for the extent action used or disclose ederal privacy regulative end copy the information the property of the extent action used or disclose ederal privacy regulative end copy the information that the property of the pr	in 90 days. ion at any time by notifyi has already been taken in d pursuant to this authorition (HIPAA).	ONLY IF APPLICANT IN THE PROPERTY OF THE PROPE	A. in writing, redisclosure b	and it will be effectively the recipient and not fithis form if I sign it
I specifically author Covering the period	ealth & SUBSTA prize the release of info od(s) of healthcare: F enature of Patient or Le AD & INITIAL: understand that this aut understand that I may re the date notified except understand that informance be protected by Fo understand that I may see	Fax Mance ABUSE (P) Ormation relating to mean from/ _/ egal Guardian horization will expire revoke this authorization attoon used or disclose ederal privacy regulative and copy the information is voluntary to contact the copy the information is voluntary to the copy the copy that the copy the copy that the	in 90 days. ion at any time by notifyi has already been taken in d pursuant to this authorition (HIPAA).	ONLY IF APPLICATION ONLY IF APPLICATION ONLY IF APPLICATION ON THE PROPERTY OF	A. in writing, redisclosure b	and it will be effectively the recipient and note this form if I sign it
Initial 1. It initial 3. It initial 4. It initial 4. It initial 5. It initial 6.	EALTH & SUBSTA Drize the release of info od(s) of healthcare: Fe anature of Patient or Le AD & INITIAL: Inderstand that this aut in the date notified except understand that informager be protected by Fe understand that I may se	Fax Mance ABUSE (Plantation relating to manager of the promation will expire revoke this authorization to the extent action attempt to the extent action used or disclose ederal privacy regulation used or disclose ederal privacy regulation and the promator of the extent action and the promator of the p	in 90 days. ion at any time by notifyi has already been taken in d pursuant to this authorition (HIPAA).	ONLY IF APPLICANT IN THE PROPERTY OF THE PROPE	A. in writing, redisclosure b	and it will be effectively the recipient and note this form if I sign it
Initial 1. Initial 3. Initial 4. Initial 1. Initial 5. Initial 6. Initial	EALTH & SUBSTA prize the release of info od(s) of healthcare: F enature of Patient or Le AD & INITIAL: understand that this auti understand that I may re the date notified excel- understand that informa- nger be protected by Fe- understand that I may se understand th	Fax Mance ABUSE (P) Ormation relating to mean from/ _/ egal Guardian horization will expire revoke this authorization attoon used or disclose ederal privacy regulative and copy the information is voluntary to contact the copy the information is voluntary to the copy the copy that the copy the copy that the	in 90 days. ion at any time by notifyi has already been taken in d pursuant to this authoriton (HIPAA). mation described in this for	ONLY IF APPLICANT IN THE PROPERTY OF THE PROPE	A. in writing, redisclosure tell get a copy cattiesburg Clin	and it will be effectively the recipient and note this form if I sign it
I specifically author Covering the periods	contact the release of informature of Patient or Leanature or	ANCE ABUSE (PI Dormation relating to me From// Egal Guardian Provide this authorization used or disclose ederal privacy regulative ee and copy the information is voluntarie affected. OR OR	in 90 days. ion at any time by notifyi has already been taken in d pursuant to this authorion (HIPAA). mation described in this for y. If I do not sign this form	nce abuse records. Date Date In Hattiesburg Clinic, P. reliance upon it. reliance upon it. reliance upon it. remains to the remains a subject to the remains a subject to remain if I ask for it, and I wim, my healthcare from Hattiesburg Clinic, P. reliance upon it.	A. in writing, redisclosure to attiesburg Cline PERSON	and it will be effectively the recipient and not fithis form if I sign it ic and the payment for DATE
I specifically author Covering the periods in the period in the periods in the period in the periods in the period in the periods in the period in the periods in the period in th	contact the release of informature of Patient or Leanature or	Fax Mance Abuse (P) Ance Abuse (P) From/_/ From// From	in 90 days. ion at any time by notifyi has already been taken in d pursuant to this authorition (HIPAA). nation described in this for y. If I do not sign this form PARENT/LEGAL GUA RELATIONSHI My parental rights have	Date Date Date Date In g Hattiesburg Clinic, P. and I with the properties of the	A. in writing, redisclosure to attiesburg Cline PERSON	and it will be effectively the recipient and not fithis form if I sign it ic and the payment for DATE
I specifically author Covering the periods in the periods on the periods of the p	cod(s) of healthcare: For an ature of Patient or Lean ature of Patient	ANCE ABUSE (PI Dormation relating to me From/ regal Guardian Are revoke this authorization will expire revoke this authorization to the extent action ation used or disclose rederal privacy regulative earned copy the information is voluntary affected. OR ATE *** FOR HBC U	in 90 days. ion at any time by notifyi has already been taken in d pursuant to this authorision (HIPAA). mation described in this for y. If I do not sign this form PARENT/LEGAL GUA RELATIONSHI My parental rights have	ONLY IF APPLICATION ONLY IF APPLICATION ONLY IF APPLICATION ON THE PROPERTY OF	A. in writing, redisclosure to attiesburg Clin	and it will be effectively the recipient and not find this form if I sign it ic and the payment for DATE
I specifically author Covering the periods on the periods of the p	cod(s) of healthcare: For an ature of Patient or Lean ature of Patient	Fax Mance Abuse (P) Ance Abuse (P) From/_/ From// From	in 90 days. ion at any time by notifyi has already been taken in d pursuant to this authorision (HIPAA). mation described in this for y. If I do not sign this form PARENT/LEGAL GUA RELATIONSHI My parental rights have	ONLY IF APPLICATION ONLY IF APPLICATION ONLY IF APPLICATION ON THE PROPERTY OF	A. in writing, redisclosure to attiesburg Cline PERSON	and it will be effectively the recipient and not find this form if I sign it ic and the payment for DATE