



Authorization for Disclosure of Medical Information

PATIENT NAME: _____ LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____ - _____ - _____ SS#: _____ - _____ - _____ MEDICAL RECORD #: _____
MO DAY YEAR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize [] Hattiesburg Clinic, P.A. or _____ to release information from my medical record as indicated below to:

[] Myself [] Person or Organization identified below:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED (include dates if appropriate): _____

I specifically authorize the release of information relating to: _____ Mental health (including psychotherapy notes)
X
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ___ Changing physicians ___ Consultation/second opinion ___ Continuing care
___ Legal ___ School ___ Insurance ___ Workers Compensation
___ Patient Request ___ Other (please specify): _____

- 1. I understand that this authorization will expire in 90 days or on _____.
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.
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 regulations.
4. 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.
5. 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.
6. I understand that in compliance with Mississippi regulations (currently Mississippi State Board of Medical Licensure), I will pay a fee of \$_____.

SIGNATURE OF PATIENT DATE OR _____ PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

My parental rights have not been terminated. (In the case of signing for a minor child).

RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

WITNESS DATE

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____
IDENTIFICATION PRESENTED: _____ FEE COLLECTED: \$ _____ 0603-A (3/23/10)