PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Dermatology Center of North Mississippi, P.A.

516 Pegram Dr. Tupelo, MS 38801 phone 662-844-6272 fax 662-844-1603 www.tupelodermcenter.com

100 Norman Road Corinth, MS 38834 phone 662-205-4762 fax 662-594-1620

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Phone: _____

I authorize the following organization to release information as stated below from the patient health information record:

INFORMATION TO BE RELEASED FROM:

_____
Organization

_____
Street Address City, State, Zip

_____
Phone Fax

INFORMATION TO BE RELEASED TO:

_____
Organization

_____
Street Address City, State, Zip

_____
Phone Fax

INFORMATION TO BE RELEASED

Dates of service for records requested: Beginning _____Thru_____

- Discharge Summaries
- Operative Reports
- Radiology Reports
- Lab/Pathology Report
- Clinic Notes
- Other (please specify) _____

Format for records (please circle only one): Paper Fax

Please note if a format is not selected, records will be in paper format.

PURPOSE OF RELEASE

- Continuing of care
- Copies for own use
- Transfer to another provider
- Legal
- Other _____

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 516 Pegram Dr Tupelo, MS 38801. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition:

  _____

  If I fail to specify an expiration date/event/condition, this authorization will expire 3 years from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

_____

Signature of Patient or Legally Responsible Party Date (month/day/year)

_____

Relationship to patient, if not signed by patient