

**PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Dermatology Center of North Mississippi, P.A.**

**340 Court St Tupelo, MS 38804 phone 662-844-6272 fax 662-844-1603 [www.tupelodermcenter.com](http://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:**

**INFORMATION TO BE RELEASED TO:**

\_\_\_\_\_  
Organization

\_\_\_\_\_  
Organization

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Phone Fax

\_\_\_\_\_  
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**

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Signature of Patient or Legally Responsible Party

Date (month/day/year)

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Relationship to patient, if not signed by patient