MISSISSIPPI STATE HOSPITAL
Authorization for Release of Health Information

Patient Information Medical Record: _________________________

Name: ____ DOB: ___/___/___ SSN: ___________________

Address: ____

City/State/Zip: ____

Release Information

Name of Facility Releasing Information : ____

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Name of Facility Information will be Released TO: ____

Address: ____

Phone: ______________________ Fax: __________________________

Purpose of Release

____ Personal ____Legal/Attorney ____Insurance ____Disability ____Continuing Care

____School ____Workman's Compensation ____Other: (specific): _____________________________

PHI to be Released

Format for Release: ____Paper ____Electronic ____View Access as scheduled ____ Verbal

Service Dates: _________________________ Information needed by(optional): ____________________

Indicate by **initialing** and/or describing the amount and type of health information to be viewed/released):

____ Admission Summary ____ Discharge Summary ____ History and Physical

____ Consultation Reports ____ Operative Reports ____ Emergency Room Record

____ Laboratory Reports ____ Radiology Reports ____ Progress Notes

____ Physicians' Orders/Notes ____ Other: ____

Sensitive Information Released: In understand that this health information may include sensitive information. By Signing this form, I specifically authorize the release of each *initialed* sensitive information item:

____ Substance Abuse Assessment/Treatment Records ____ Mental Health Information

____ HIV related information ____ Other Abuse

Expiration Date of this authorization:_ ______________ (If no date, it will expire within 12 months from signature)

Patient's Rights

I understand that I may revoke this authorization by putting the request in writing to the Health Records Department at Mississippi State Hospital. I understand that my revocation will not apply to any information that has already been released in response to this authorization. I understand this form is voluntary and I do not need to sign this form to receive treatment. I understand that I am entitled to a copy of this form after I sign it. I understand the information disclosed from this authorization may be subject to redisclosure by the recipient and no longer protected by Federal Privacy Regulations. If I have questions about disclosure of my health information, I can refer to the Hospital's Notice of Privacy Practices or contact the Mississippi State Hospital Privacy Officer. I understand that this includes the disclosure of sensitive information released. I have read the patient's rights and voluntarily authorize the disclosure of all the information requested in this authorization. **I acknowledge this authorization with my signature below**:

______________________________________	___________________________________	_________________
Signature of patient/representative	Description/Relation	Date & Time
______________________________________	___________________________________	_________________
Witness	Title	Date & Time

MSH 205 (5/22)