DEPARTMENT OF MENTAL HEALTH
OAK CIRCLE CENTER
JAQUITH NURSING HOME
MISSISSIPPI STATE HOSPITAL
WHITFIELD MEDICAL SURGICAL HOSPITAL

Authorization to Release or Obtain Protected Health Information

Patient Information

Name: _____ SID Number: _____

Race: _____ Sex: _____ Date of Birth: _____

Authorized Healthcare Representative (if applicable): _____

I, _____ or
(Name)

I, as the _____ hereby
(parent / authorized healthcare representative)

authorize _____
(Name of Provider Entity)

to release or obtain (circle) my protected health information/records to/from:

_____
(Name of Person and Title or Entity and Address to whom/from whom information will be disclosed/obtained)

I specifically authorize/consent to the release or obtaining (circle) of health information/records pertaining to the following:

Must indicate by initialing and/or describing the amount and type of health information to be obtained/released):

_____ Admission Summary	_____ Discharge Summary	_____ History and Physical
_____ Consultation Reports	_____ Operative Reports	_____ Emergency Room Record
_____ Laboratory Reports	_____ Radiology Reports	_____ Progress Notes
_____ Nurses' Notes	_____ Substance Abuse Assessment/Treatment Records	

_____ EKG/Other Electrophysiology Studies

_____ Physicians' Orders/Notes (except Psychotherapy Notes)

_____ Other Treatment Plans and Related Revisions, Progress Notes and Summaries (except Psychotherapy Notes) for (list area(s): psychology, medical/nursing, education, etc.)

_____

_____ Other (Describe other information/records to disclosed/obtained)

_____

_____

_____

for the specific purpose of _____

_____

_____
(Describe purpose or nature of the information to be disclosed/obtained)

If entire health record is requested, indicate specific reason that entire record is needed:

_____

_____

_____

Date of service for which the information/record is requested or will be released:

From: _____ To: _____

I understand that this authorization/consent will be effective on _____ and
(effective mo/day/year)

will expire on _____
(Indicate mo/day/year, event or condition, not to exceed six months for psychiatric/substance abuse facility; not to exceed one year for Alzheimer's Disease/other dementia programs)

and cannot be renewed without my written authorization/consent.

I understand that to revoke this authorization, I must provide a specific request to revoke the authorization in writing to the Health Records Department at Mississippi State Hospital.

I understand that my revocation will not apply to action or any information that has already been released/obtained in response to this authorization.

I understand that my authorizing the disclosure/obtaining of this health information is voluntary. I understand that I need not sign this form in order to receive treatment. I understand that I may inspect or copy information to be used or disclosed as provided for by law. I understand that to revoke this authorization, I must provide a specific request to revoke authorization in writing to the Health Records Department at Mississippi State Hospital. 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.

_____ _____ _____
(Signature of Individual, if applicable) (Date) (Time)

_____ _____ _____
(Signature of Parent/Guardian/ Judicially Authorized Representative, if applicable) (Date) (Time)

(Attach or include description of such representative's authority to act for the client/patient, if applicable.)

_____ _____ _____
(Date) (Time)

_____ _____ _____
(Signature(s) of Witness(es), if applicable) (Date) (Time)

NOTICE TO RECIPIENT OF THIS INFORMATION : This information has been disclosed to you from records whose confidentiality has been protected. Statutes/regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

_____

(Provider Entity staff must provide a copy of the signed authorization to the client/patient and/or judicially authorized representative.)