Medical Record #:_____

The University of Mississippi Medical Center (UMMC)
Authorization for Release of Health Information

** Forms that are not complete will not be accepted by UMMC. **

Please select the location for which you authorize to release your protected health information (PHI).

❑ **Jackson:** 2500 North State Street Jackson, MS 39216
❑ **Grenada:** 960 J K Avent Drive Grenada, MS 38901
❑ **Lexington:** 239 Bowling Green Road Lexington, MS 39095
❑ **Clinic/Other** (specify):_____

Patient Information

Patient Name:_____DOB: ___/____/____ SSN: _____

Address: _____

City/State/Zip:_____Phone: _____

Release Information

Release to: _____

Address: _____

Phone:_____Fax: _____

Purpose of Release

❑ Personal ❑ Legal/Attorney ❑ Insurance ❑ Disability ❑ Continuing Care ❑ School

❑ Worker's Compensation ❑ Other *(be specific):* _____

PHI to be Released

**** Format of Release**: ❑ Paper ❑ Electronic ❑ View Access as scheduled*

Service Dates: From ____/___/___To___/____/___ Information Needed by (*Optional*):___/____/_____

❑ History & Physical
❑ Operative Report
❑ Operative Notes
❑ Discharge Summary
❑ Laboratory Reports
❑ Radiology Reports
❑ ER Report
❑ Immunization Record
❑ Physical Therapy Notes
❑ Occupational Therapy Notes
❑ Dental Records
❑ Entire Medical Record
❑ Other: _____

Sensitive Information Release: I 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 Treatment Information____
❑ Mental Health Information_____
❑ Genetic Testing_____
❑ HIV related information, including AIDS related testing_____
❑ Other Abuse_____

Patient's Rights

This authorization will *expire 6 months from the date of signature*. I understand that when I give my permission to release my health information or take my permission away from another facility or person, I must contact that party. If you wish to take your permission away, please send a written notice with signature and date of patient information that was to be released to: UMMC, Attention: Office of Integrity & Compliance, 2500 North State Street, Jackson, MS 39216-4505. The notice should include detailed information as identified in the original authorization request. I understand that information used or disclosed pursuant to this authorization *may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations*. I understand this form is voluntary and *UMMC will not condition my treatment on giving this authorization*. I understand that I am entitled to receive a copy of this form after I sign it. I have carefully read and understand the Patient's Rights above, and do herein expressly and voluntarily authorize the disclosure of all the information requested in this authorization including the "Sensitive Information Release". **I acknowledge this authorization with my signature below.**

_____ _____ _____/_____/_____

***Signature of Patient/Representative* ***Representative Description* *Date*

Witness _____ *Date*_____/____/_____

*** If this form is being signed on the behalf of a patient's representative, the person signing must document relationship above.*
***If the patient listed above is under the age of 18, this authorization form (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the behalf other minor. As the person signing for the patient, I, the parent, guardian, party acting as loco parentis, or legal representative warrant that I have the legal authority to act on behalf of the patient and that I am not prohibited by Court order or law from having access to the requested medical records.*