

1720-A Medical Park Drive, Ste. 240 Biloxi, MS 39532 • 228-396-5100



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Date of Bitald Daytinac Tolephone Number SEND INFORMATION TO: (please be specific) Provider Name/Organization: Address: Phone #:		
SEND INFORMATION TO: (please be specific) Provider Name/Organization: Address: Fax #: INFORMATION TO BE RELEASED FROM: (please be specific) Provider Name/Organization: Address: Fax #: Please of Service: Transfer of care Self Specialist Other (must complete local Records from last two years Dates of Service: Gaust complete Designated Record Set Other Expiration Date (or event) If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not attendy been disclosed. Please set our Notice of Privacy Practices for instructions as to how to revoke this authorization. Wall not condition treatment on the completic of the authorization, and no longer be protected by the HIPAA of 1996. As applicable, I have received a copy of the Notice of Privacy Practices. (Patient Initials) Date Signature of patient or representative Relationship to patient DISCLOSURES REQUIRING SPECIAL CONSENT: My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for: HIV/AIDS Virus Mental Health/Psychiatric Disorders Drug, Alcohol Abuse/Treatment Date Signature of patient or representative Relationship to patient Date Drug, Alcohol Abuse/Treatment Drug, Alcohol Abuse/Treatment	Printed Name of Patient	Previous Names, If Applicable
Provider Name/Organization: Address: Phone #:	Date of Birth	Daytime Telephone Number
Address: Phone #:	SEND INFORMATION TO: (please be specific)	
Phone #:	Provider Name/Organization:	
Phone #: Fax #:	Address:	
Provider Name/Organization: Address: Phone #:		
Provider Name/Organization: Address: Phone #:	Phone #:	Fax #:
Address:	INFORMATION TO BE RELEASED FROM: (please be speci	fic)
Phone #:	Provider Name/Organization:	
Phone #:	Address:	
INFORMATION TO BE DISCLOSED: Medical Records from last two years Summary Health Information		Fax #:
INFORMATION TO BE DISCLOSED: Medical Records from last two years Summary Health Information	PURPOSE OF DISCLOSURE: □ Transfer of care □ Self □	I Specialist □ Other (must complete)
Medical Records from last two years Summary Health Information Dates of Service: Complete Designated Record Set Other Expiration Date (or event) If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please se our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completic of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996. As applicable, I have received a copy of the Notice of Privacy Practices		(mast complete)
□ Summary Health Information □ Complete Designated Record Set □ Other		
Complete Designated Record Set Other	· · · · · · · · · · · · · · · · · · ·	Dates of Service:
If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please se our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completic of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to redisclosure and may no longer be protected by the HIPAA of 1996. As applicable, I have received a copy of the Notice of Privacy Practices(Patient Initials) Date	· ·	
be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please secour Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completic of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to redisclosure and may no longer be protected by the HIPAA of 1996. As applicable, I have received a copy of the Notice of Privacy Practices	☐ Other	Expiration Date (or event)
DISCLOSURES REQUIRING SPECIAL CONSENT: My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for: HIV/AIDS Virus	our Notice of Privacy Practices for instructions as to how to revoke of the authorization. Also, please be aware that once we disclose the	e this authorization. We will not condition treatment on the completion his information per your instructions the information is subject to re-
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for: HIV/AIDS Virus	Date Signature of patient or representative	Relationship to patient
□ HIV/AIDS Virus □ Mental Health/Psychiatric Disorders □ Drug, Alcohol Abuse/Treatment □ Drug, Alcohol Abuse/Treatment □ Relationship to patient For Facility Use: Date Received: □ Date Information Released: □ Chart # □	DISCLOSURES REQUIRING SPECIAL CONSENT:	
□ Sexually Transmitted Diseases □ □ Drug, Alcohol Abuse/Treatment □ Date Signature of patient or representative Relationship to patient For Facility Use: Date Received: □ Date Information Released: □ Chart # □	My signature below specifically authorizes the release of healthcar	re information relating to the testing, diagnosis, or treatment for:
Date Signature of patient or representative Relationship to patient For Facility Use: Date Received: Date Information Released: Chart #	☐ HIV/AIDS Virus	☐ Mental Health/Psychiatric Disorders ☐
For Facility Use: Date Received: Date Information Released: Chart #	☐ Sexually Transmitted Diseases	☐ Drug, Alcohol Abuse/Treatment
Date Received: Date Information Released: Chart #	Date Signature of patient or representative	Relationship to patient
Person/Department Sending Records:		