Southwest Mississippi Regional Medical Center

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____SMRMC_____to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requester Name: _____

Requester Address: _____

_____

Patient Name: _____

Patient DOB: _____

Patient SS#: _____

Patient Phone: _____

Patient Address: _____

_____

Disclose the following PHI for treatment dates_____to _____

☐ Abstract/Pertinent ☐ History & Physical ☐ Discharge Summary ☐ Consult
☐ Operative Report ☐ Progress Notes ☐ Physician Orders ☐ Nurses Notes
☐ ER Report ☐ Lab ☐ X−ray ☐ Entire chart
☐ Other Specified:_____

The above information is disclosed for the following purposes:
☐ Medical Care ☐ Legal ☐ Insurance ☐ At the request of patient ☐ Other_____

_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.
(initials)

This authorization shall expire upon this expiration date:_____
If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.
A copy of this authorization is valid as the original.

> I understand that I may revoke this authorization at any time in accordance with SMRMC?s Notice of Privacy Practices. Please send written requests to revoke authorizations to SMRMC, Director of Health Information Management, 215 Marion Ave., McComb, MS 39648. I understand that this revocation will not apply to information that has already been released pursuant to this authorization.
> The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by federal and/or state privacy laws and regulations.
> I understand that my treatment or continued treatment by SMRMC is in no way conditioned on whether or not I sign this authorization. I understand I may refuse to sign this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient:_____

_____ _____
Signature of Witness Date

THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL ENTRIES ARE COMPLETED
Provide Copy to Patient

Rev 7/09, 7/12, 6/14, 10/16 econvert

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