



**Authorization for Release of Protected Health Information to
Mississippi Center for Advanced Medicine**

Patient Name

Patient Date of Birth

Parent/Legal Guardian Name

Relationship to Patient

I hereby authorize: _____ to
disclose the protected health information specified below to:

Mississippi Center for Advanced Medicine

7730 Old Canton Rd, Bldg A, Madison, MS 39110
Phone: (601) 499-0935 / Fax: (601) 499-0936

7730 Old Canton Rd, Bldg B, Madison, MS 39110
Phone: (601) 499-0935 / Fax: (601) 499-0936

401 Baptist Dr, Ste 301, Madison, MS 39110
Phone: (601) 499-0935 / Fax: (601) 499-0936

330 West Jefferson St, Tupelo, MS 38804
Phone: (662) 432-0200 / Fax: (662) 432-0199

I authorize the Practice to disclose the following health information to the above specified party:

- Verbal information only informing the above person(s) about my medical information without the production of any written records.
- My complete medical records and information including but not limited to, test results, as well as information related to HIV status, drug and alcohol usage, and mental health status (but this Authorization does not include an authorization for the release of psychotherapy notes).
- My medical records for the specific treatment dates from _____ to _____.
- The following specific portions of my medical records and health information: _____

1. I authorize the Practice to use and/or disclose my health information for the following purposes.

- At my request, or
- For the following purposes*: _____

2. This authorization expires:

- On the following date: _____
- When the following event occurs: _____

3. I understand that I have the right to revoke this Authorization at any time and that revocation must be delivered in writing to MCAM's office manager. I am aware that my revocation will not be effective if (i) this Authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself; or (ii) to the extent MCAM has already acted in reliance upon this Authorization.

4. I understand that I am under no obligation to sign this form and that MCAM may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this Authorization.

5. I understand that if the persons I have authorized by this release to obtain my health information are not health care providers, health plans or health care clearinghouses subject to the federal privacy standards, the health information disclosed pursuant to this Authorization may no longer be protected by the federal privacy standards and such persons may be able to re-disclose my health information without obtaining my authorization.

Patient's Signature

Date and Time

*If the Authorization is intended to authorize us to disclose records concerning drug or alcohol treatment, federal law requires you to state the purpose of the disclosure.

PATIENT'S LEGAL REPRESENTATIVE MUST PROVIDE PROPER DOCUMENTATION

The above patient is unable to consent because:

- Minor
- Incompetent
- Other (explain): _____

I therefore consent on behalf of the patient named above.

Signature

Relationship

Date and Time

The individual signing this Authorization is entitled to a copy of this Authorization when it is signed.