AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

______________________________________ ______ / ______________ / __________________

Name of Patient/Previous Names — Birth Date/Social Security Number/Phone Number

______________________________________ ______________________________________

Street Address — City, State, Zip

I hereby authorize the release of protected health information:

To/From

P O Box 6338 Mississippi State, MS 39762
Phone: 662 325-2431 Fax: 662 325-8888

To/From ______________________________________

Name

____

Street

____

City, State, Zip

____

Phone Fax

SPECIFIC INFORMATION TO BE RELEASED:

___ Medical History, Examination, Reports
___ Immunizations
___ X-ray Reports
___ Allergy Records
___ Laboratory Reports
___ Entire Record
___ Other (Specify): ______________________________________

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

___ Further Medical Care
___ Legal Investigation or Action
___ Personal
___ Insurance Eligiblity/Benefits
___ Changing Physicians
___ Other (Specify): ______________________________________

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the privacy officer. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the privacy officer. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) ________________or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: ______________________________________**DATE:** ________

(If signed by other than patient, state relationship and authority to do so.)

WITNESS: ______________________________

For Student Health Service Use Only

Information to be ____ Mailed ____Picked Up ____ Faxed ____ Other ________________ Date Needed: ____________

Information sent by: ______________________________________ Date: ______________________________

Employee Name/Signature