WOMEN'S PAVILION
OF SOUTH MISSISSIPPI

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO WOMEN'S PAVILION OF SOUTH MISSISSIPPI, P.L.L.C.

DATE: _____

Patient Name: _____ (Maiden Name: _____)

Social Security Number: _____ Date of Birth: _____

Address: _____ Telephone Number: _____

I authorize the following provider to release my information to Women's Pavilion of South Mississippi, P.L.L.C., 39 Franklin Road, Suite 300, Hattiesburg, MS 39402, or fax: (601) 268–9559. Telephone: (601) 268–9393.

_____
PROVIDER AND FACILITY NAME

_____ _____
ADDRESS FAX NUMBER

_____ _____
CITY, STATE, ZIP TELEPHONE NUMBER

DATES MUST BE COMPLETED

RELEASE OF INFORMATION REGARDING DATE(S) OF SERVICE – From: _____ To: _____

Check all that apply:

___ Progress Notes ___ Lab ___ Radiology ___ Nurses Notes
___ Discharge Summary ___ Physician Orders ___ Consult ___ Entire Record

THIS DISCLOSURE IS BEING MADE FOR THE FOLLOWING PURPOSE(S):

___ Continuing Care ___ Transfer of Care ___ Workers' Compensation Case
___ Attorney/Court Case ___ Insurance ___ Personal Reasons
___ Other: _____

I understand that the information in my record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules. I also understand that the degree of confidentiality can be modified with a facsimile. It is my choice to have my records faxed, rather than mailed. _____ (initial here)

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Unless otherwise revoked, this authorization for disclosure of information is effective for six (6) months from the date signed.

PATIENT SIGNATURE _____ DATE _____

or

SIGNATURE of
LEGAL REPRESENTATIVE _____ DATE _____

RELATIONSHIP OF LEGAL REPRESENTATIVE Check one: ___ Legal Guardian ___ Spouse of Deceased ___ Executor of Estate ___ Power of Attorney for Health Care ___ Other: _____

WITNESS _____ DATE _____