Effective as of
May 12, 2008

SINGING RIVER HEALTH SYSTEM

## AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

**Patient's Name :** **MEDICAL RECORD # :**

**SSN :**

**ROI ONLY**

**Date of Birth :** **ACCOUNT# :**

**Phone # :**

**Address :** **REQUEST I.D. # :**

**I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.**

1. **PERSONS/ORGANIZATIONS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION : (place of treatment)**
   - ☐ Singing River Hospital
   - ☐ SRHS Clinics
   - ☐ Ocean Springs Hospital

2. **PERSON/ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION : (who will be getting these records)**
   - ☐ Patient or Patient's Legal Guardian/Representative
   - ☐ Physician _____ Office#: (_____)_____ FAX#: (_____)_____
   - ☐ OTHER – person authorized to pick-up your records: _____ relation: _____

3. **SPECIFIC DESCRIPTION OF INFORMATION THAT MAY BE USED OR DISCLOSED : (dates of service)**

   **Date (s) of Service :**

   Needed from the records :

   ☐ ABSTRACT ☐ Dictation ☐ Mental Health ☐ HIV
   ☐ COMPLETE ☐ Tests ☐ Drug\Alcohol ☐ OTHER _____

4. **THE INFORMATION WILL BE USED\DISCLOSED FOR THE FOLLOWING PURPOSE : (reason for wanting records)**
   - ☐ Continuation of Care ☐ Insurance Purposes ☐ OTHER _____
   - ☐ Personal Record ☐ Releasing to an Attorney

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.
6. I understand that I may inspect or copy the information used or disclosed.
7. I understand that I may revoke this authorization at any time by notifying the person/organization providing this the information in writing, except to the extent that: (A) action has been taken in reliance on this authorization; or (B) authorization is obtained as a condition for obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under policy.
8. **This authorization will expire in 6 months unless otherwise stated.** _____

_____ _____/_____/_____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative OR Authority to act for the patient — Relationship to Patient

SRHS Employees: A copy of this signed form will be provided to the patient