



**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:

- | | | | |
|--|---|------------------------------------|--|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Lab | <input type="checkbox"/> Radiology | <input type="checkbox"/> Nurses Notes |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Consult | <input type="checkbox"/> Entire Record |

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Workers' Compensation Case |
| <input type="checkbox"/> Attorney/Court Case | <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal Reasons |
| <input type="checkbox"/> 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 _____