Effective as of
May 12, 2008

Singing River
Health System

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Patient's Name : _____

SSN : _____

Date of Birth : _____

Phone # : _____

MEDICAL RECORD # : _____

REQUEST I.D. # : _____

FOR HIM USE ONLY

Address : _____

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 redisclosed and no longer protected by federal privacy regulations.

1. PERSONS/ORGANIZATIONS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION : (place of treatment)

   ☐ Singing River Hospital ☐ Singing River Health System Clinics _____

   ☐ Ocean Springs Hospital ☐ Other _____

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 of patient's representative OR Authority to act for the patient

Relationship to Patient

Singing River Health System Employees: A copy of this signed form will be provided to the patient upon request.