The University of Mississippi
Authorization for Release of Protected Health Information

Forms that are not complete will not be accepted

Patient Information

Patient Name: _____ DOB: ___/___/_____

Address: _____

City/State/Zip: _____ Phone: _____

Release Information

Release To or From: _____

(please circle To or From)

Address: _____

Phone: _____ Fax: _____

Purpose of Release

❑ Personal ❑ Legal/Attorney ❑ Insurance ❑ Disability ❑ Continuing Care ❑ School

❑ Worker's Compensation ❑ Other *(be specific):* _____

Protected Health Information to be Released

***Format of Release**: ❑ Paper ❑ Electronic ❑ View Access as scheduled*

Service Dates: From ___/___/_____ To ___/___/_____ Information Needed by (*Optional*): ___/___/_____

❑ History & Physical	❑ Laboratory Reports	❑ Physical Therapy Notes
❑ Operative Report	❑ Radiology Reports	❑ Occupational Therapy Notes
❑ Operative Notes	❑ ER Report	❑ Dental Records
❑ Discharge Summary	❑ Immunization Record	❑ Entire Medical Record

❑ Other: _____

Sensitive Information Release: I understand that this health information may include sensitive information. By signing this form I specifically authorize the release of each *initialed* sensitive information item:

Substance Abuse Treatment Information ____
Mental Health Information _____
Genetic Testing _____

HIV related information, including AIDS related testing _____
Other Abuse _____

Patient's Rights

This authorization **will *expire 6 months from the date of signature***. I understand that when I give my permission to release my health information or take my permission away from another facility or person, I must contact that party. If you wish to take your permission away, please send a written notice with signature and date of patient information that was to be released to: **University of Mississippi, Attention: Dr. Travis W. Yates, PO Box 1848, Student Health Service, University, MS 38677.** The notice should include detailed information as identified in the original authorization request. I understand that information used or disclosed pursuant to this authorization ***may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations***. I understand this form is voluntary and *the* ***University of Mississippi will not condition my treatment on giving this authorization*.** I understand that I am entitled to receive a copy of this form after I sign it. I have carefully read and understand the Patient's Rights above, and do herein expressly and voluntarily authorize the disclosure of all the information requested in this authorization including the "Sensitive Information Release". **I acknowledge this authorization with my signature below.**

_____ _____ _____/_____/_____

**Signature of Patient/Representative* ***Representative Description* *Date*

Witness _____ *Date* _____/_____/_____

**If the patient listed above is under the age of 18, this authorization form (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the behalf other minor, except for sexual health. As the person signing for the patient, I, the parent, guardian, party acting as loco parentis, or legal representative warrant that I have the legal authority to act on behalf of the patient and that I am not prohibited by Court order or law from having access to the requested medical records.*

*** If this form is being signed on the behalf of a patient's representative, the person signing must document relationship above.*