North Sunflower Medical Center
Take Me To Ruleville

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name:	**Account #:**
Date of Birth:	**Phone Number:**
Address:	**City, State, Zip Code:**

I hereby authorize North Sunflower Medical Center **to release or obtain** the below information contained in my medical record:

Receive From:	**Send To:**
Address:	**Address:**
City, State, Zip Code	**City, State, Zip Code**
Phone:	**Phone:**
Fax:	**Fax:**

PURPOSE OF DISCLOSURE:

☐ Continuity of Care ☐ Insurance Claim ☐ Personal
☐ Legal Matter ☐ Other (Specify):

_____

SPECIFIC INFORMATION TO BE DISCLOSED:

☐ Office Visit/Progress Notes ☐ Laboratory Reports ☐ EKG/Cardiac Testing
☐ Tissue Report ☐ Operative Report ☐ History and Physical Only
☐ Radiology Reports (x-ray, CT, MRI, etc.) ☐ Consultations
☐ Other (Specify): _____

DATES OF SERVICES:

☐ All (you are only permitted to view information dated on or prior to date of this authorization).
☐ _____ (specific date(s) of service).

EXPIRATION DATE or EVENT: _____

I authorize the release of the above information relating to my general medical treatment and/or any treatment relating to alcohol/drug abuse, mental illness, psychiatric treatment, developmental disabilities, HIV/AIDS, Gonorrhea, Hepatitis (viral), Syphillis, Chancroid, Chlamydial infections, or Lymphagranuloma Venereum. I further authorize the information to be faxed or electronically sent.

☐ This box must be checked if you **DO NOT** want the following information released:
Drug and/or alcohol abuse, or for psychiatric and/or mental conditions, or HIV test results or diagnosis.

I understand this authorization may be revoked at any time, providing the information has not already been disclosed. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Reid Physician Associates, Inc. I also understand that once the above information has been disclosed per my instruction, the information may no longer be protected by the confidentiality laws. Unless otherwise specified or revoked, this authorization will expire in 60 days unless the disclosure is to myself which will automatically expire 60 days from the date of my signature on this form. **I hereby state that I have read and fully understand the above statements.**

_____ _____ _____
Date Signature of Patient or Legal Representative Driver's License/Other ID

_____ _____
Relationship to Patient, if signed by Legal Representative
Signature of Witness

☐ Durable Health Care Power of Attorney – attending physician has declared patient incapable of consent.