North Sunflower Medical Center
Take Me To Ruleville

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name:	**MRN/Visit #:**
Date of Birth:	**Phone Number:**
Mailing Address, City, State & Zip Code:	
Email Address:	

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

Send To:
Address:
City, State, Zip Code:
Phone:
Fax:

PURPOSE OF DISCLOSURE: Please check all that apply.

☐ Continuity of Care ☐ Insurance Claim ☐ Personal

☐ Legal Matter ☐ Other (Specify): _____

SPECIFIC INFORMATION TO BE DISCLOSED: Please check Information requesting to be released. Charges may apply.

☐ Face Sheet
☐ Discharge Summary/Instruction
☐ History and Physical Report
☐ Consultation Reports
☐ Operative Reports
☐ Pathology Reports
☐ Laboratory Reports *(Specify DOS)* _____
☐ Radiology Reports *(Specify DOS)* _____
☐ Progress Note Report/Office Visit
☐ (MAR) Medication Administration Record
☐ Nursing Notes
☐ Other *(Specify)* _____

DATES OF SERVICES:

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

OR

☐ _____List 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 North Sunflower Medical Center. 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 fullyunderstand the above statements.

Date | Signature of Patient or Legal Representative | Driver's License/Other ID
Please provide form of ID for Verification

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.