# NORTH MISSISSIPPI HEALTH SERVICES

# SOUTH MARION

Release of Information Form

Patient Name: _____ Date of Birth: _____

Account Number: _____ Releasing Facility: North Mississippi Health Services - South Marion

Date of Service: _____ _____ Purpose of Disclosure: _____

**Information to be Released**

Imaging Inpatient Records ER Records Laboratory Surgery Cardiopulmonary

CD Only DVD Only Reports Only CD & Reports DVD & Reports Other: _____

**The patient or the patient's representative must read and acknowledge the following statements:**

- I understand that the persons hereby authorized to use/disclose Information will not condition treatment or payment on my providing this authorization.
- I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
- I understand that my records contain sensitive information that I may have my physician authorize the use or disclosure of.
- I understand that I may refuse to sign this authorization and in doing so, I understand refusal to sign this authorization will not affect my treatment.
- I understand that information used and disclosed to any entity other than a health plan or healthcare provider may be subject to redisclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R 160 and 164
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*I hereby authorize the use or disclosure of my individual identifiable health information as described above. I understand this authorization is voluntary. I understand that this authorization also applies to records about me containing information about HIV, AIDS, Venereal disease, or mental disorders. "In accordance with federal regulation 42 CFP. Part 2: I also understand that release of any and all alcohol and/or drug abuse treatment that such information cannot be released without my specific authorization, except in special circumstances. Therapist notes related to mental disorders will also require a specific authorization. I understand that if the organization authorized to receive the information is not a health plan or a healthcare provider covered by federal privacy regulation, the released information may no longer be protected by federal privacy regulation.*

Signature: _____ Date: _____ Relationship: _____

**Verification Type (office Use Only)**

License _____ Note or Other: _____

Death Certificate POA Living Will Was a Copy Made Y or N Clerk Initials: _____