

*Olive Branch Family Medical Center
9075 Sandidge Center Cove
Olive Branch, Ms. 38654
Phone: 662-895-4949 Fax: 662-895-6776
Authorization for Release of Information*

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: _____ SS# _____ DOB: _____

Person/organization providing the information

Person/organization receiving the information

Release:

Complete Records _____ Laboratory results _____ Progress Notes _____

Other (specify) _____

If you do not want certain portions of your medical record released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

I authorize the health care provider to release the information specified to the organization, agency, or individual named above with the exception of:

_____ Substance abuse, if any _____ AIDS/HIV, if any

_____ Psychological or psychiatric conditions, if any

_____ Other, (specify): _____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. Patient initials: _____

I understand that I have the right to revoke this authorization at any time by presenting my written revocation to Olive Branch Family Medical Center. I understand that the revocation will not apply to information that has already been used or disclosed under this authorization... I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this authorization has not been revoked, it will be terminated on the following date, event or condition:

If I fail to specify an expiration date, event or condition, this authorization will automatically expire in 12 months.

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

If Personal Representative, the patient is unable to sign because (circle one): Minor Incompetent

Other (explain): _____