RICHLAND PRIMARY CARE CENTER
P.O.BOX 180367 ♦ RICHLAND, MS 39218-0367
PHONE (601) 932-6400 ♦ FAX (601) 932-6437

# AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

## 1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to Richland Primary Care Center to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Individual Patient's Name: _____

Your Address: _____

Your Telephone Number: _____

Your Social Security Number: _____ Your Date of Birth: _____

## 2. THE USE AND/OR DISCLOSURE AUTHORIZED

The type of information to be used or disclosed is as follows (please provide specific dates of service):

Date(s) of Service: _____

- ❑ Complete Medical Record
- ❑ Abstract of Medical Record (Progress Notes, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and Imaging Reports)
- ❑ Progress (Visit) Notes
- ❑ X-ray & Imaging Reports
- ❑ Laboratory Test Results

This information may be disclosed to and used by the following individual/organization:

Name: _____

Address: _____

Phone: _____ Fax: _____

Indicate the purpose for which you are authorizing your protected health information to be used and/or disclosed:

- ❑ Further medical care
- ❑ Legal Investigation or Action
- ❑ Changing Physicians
- ❑ Insurance Eligibility/Benefits
- ❑ Inspection/Copying of my Records
- ❑ Other (please specify) _____

## 3. ENDING THIS AUTHORIZATION

- ❑ This authorization will end on the following date: _____

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## 4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to Richland Primary Care Center. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

## 5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

## 6. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
Print Name

_____
Signature

Relationship to Patient: _____