Woman's Group of Meridian, PLLC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION

PATIENT NAME (Please Print) ____________ PATIENT'S SOCIAL SECURITY # ____________ PATIENT'S DATE OF BIRTH ____________

I hereby authorize to use or disclose of my protected Health information (PHI) as described below. I understand that this information will be given only to those identified on this form and that there is a date after which no further disclosure may be made without further authorization from me.

*Doctor/Organization to **Release Medical Records***	*Doctor/Organization to **Receive Medical Records***
NAME OF DOCTOR YOU ARE REQUESTING RECORDS FROM:	***WOMAN'S GROUP OF MERIDIAN, PLLLC*** NAME OF DOCTOR TO RECEIVE YOUR RECORDS
ADDRESS OF DOCTOR / ORGANIZATION:	**1221 24TH AVENUE** **ADDRESS** OF DOCTOR / ORGANIZATION
CITY STATE ZIP:	**MERIDIAN** **MS** **39301** CITY STATE ZIP
PHONE FAX:	**601-482-6945** **601-482-1138** PHONE FAX
ATTENTION:	**MEDICAL SECRETARY** ATTENTION

Information to be released includes and is limited to any of the information checked below:

__________ **Entire medical record:** includes diagnosis and progress notes, diagnostic test(s) and medications. This information will be used for continuing care.

__________ **Other (specify):** ____________________

The following information will be released when included in the above information unless you indicate otherwise:

- [ ] AIDS or HIV test results
- [ ] Alcohol, drug or substance abuse treatment
- [ ] Psychiatric or mental care / treatment
- [ ] Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOVE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTION TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AN MAY NOT BE DISCLOSED.
5. THIS AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE OF MY SIGNATURE. AFTER THIS DATE, WOMAN'S GROUP OF MERIDIAN WILL NEED TO OBTAIN A NEW AUTHORIZATION BEFORE RELEASING ANY FURTHER INFORMATION.
6. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

By signing below I understand and accept the terms of this authorization.

SIGNATURE OF PATIENT ____________ DATE ____________

SIGNATURE OF PATIENT'S REPRESENTATIVE (if necessary) ____________ DATE ____________

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Authorization Expiration Date (90 days from date of patient's signature)