Horn Lake Family
3102 Goodman Rd.
Horn Lake, MS 38637
Phone 662-342-6677 • Fax 662-342-1213

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name:_____ Date of Birth:_____

SSN:_____ Address:_____

I hereby authorize the release of medical records to: _____

_____

For the following purposes: _____

The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

_____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance theron before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship to Patient

Note to Office: This document should be considered one example of how a practice can begin their compliance efforts. It is provided as general guidance and does not constitute legal advice. Practices should tailor the document to meet their specific needs.