Delta Health Center, Inc.
702 Martin Luther King Rd.
Mound Bayou, MS 38762
Phone: 662.741-8832 Fax: 662-741-2268

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ born on _____ last four digits of SS# _____

Address_____ Phone:_____ , hereby authorize

Name: _____ Phone:_____ Fax: _____

Address: _____

To request the following Health Information (PHI) to be released from my medical records (check all that apply)

- ☐ Immunization Information
- ☐ Pap/Annual Results
- ☐ Lab Results (specific dates if applicable)
- ☐ All Records
- ☐ Other _____
- ☐ Psychiatric Records: _____

I Request my PHI to be released to:

Name: _____

Address: _____

City/ State/ Zip Code: _____

Phone: _____ Fax: _____

Purpose for requesting information

- ☐ Changing Physicians
- ☐ Continue Care
- ☐ Personal
- ☐ Legal

I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Director of Medical Records. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Delta Health Center will not condition my treatment, payment, health plan enrollment, or eligibility for benefits on my providing authorization for the requested use or disclosure. *I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and no longer protected by Federal Confidentiality regulations; however the recipient may be prohibited from disclosing substance abuse information.* I understand that I may inspect or copy the information to be disclosed, for a reasonable charge. Notice to receiving agency or individual: This Information is to be treated in accordance with HIPAA privacy regulations.

If I fail to specify an expiration date or event, and unless otherwise revoked, this authorization will expire six months from the date of the signature.

Print Patient Name: _____ Date: _____

Signature of Patient/ Legal Representative_____ Relationship to Patient_____

Witness _____ Date_____