3360B

Memorial Hospital & Physician Clinics

Authorization for Use and Disclosure of Health Information

Patient Name: ____ **Medical Record No**.: _________________

Patient Address: ____

Phone No.:(___)_______________ Date of Birth: ______/______/______ **Social Security No.:** ____________________

1. I authorize the following institution to use or disclose the above-named individual's health information as indicated below: *(check one and specify location)*

- ☐ Memorial Hospital at Gulfport
- ☐ Memorial Hospital at Stone County
- ☐ Memorial Outpatient Surgery Center: ____
- ☐ Memorial Physician Clinic: ____
- ☐ Memorial Nursing Home: ____
- ☐ Other (please specify): ____

2. I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that after the above-named facility discloses this information, it no longer has control over protection of the confidentiality of the information. Should the recipient redisclose the information, it will no longer be protected by the Federal Privacy Regulations.

3. Dates of Service:

____
____
____

Information to Release:

___ Discharge Summary
___ History & Physical
___ Admission Psychiatric Info
___Consultation/Evaluation
___ Verbal Exchange
___ Progress Notes
___ Operative Report
___ Lab/Path Report
___ Other: ____
____ Education Progress Report(s)
____ X-Ray Report
____ Cardiology
____ ER Report

4. I understand that the information in my health record may include information relating to:

Sexually transmitted diseases
Acquired immunodeficiency syndrome (AIDS)
Human immunodeficiency syndrome (HIV)
Behavioral or mental health services
Treatment for alcohol and drug abuse-protected by Federal Regulation 43 CFR Part 2

5. This information may be disclosed to and used by the following individual or organization:

Name: ____ Phone No.: ___________________________________

Address: ____

For the purpose of: ____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Memorial's Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _________________. If I fail to specify an expiration date, event, or condition, this authorization will expire in one year.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR § 164.524. I understand that any disclosure of information carries with it the potential for unauthorized disclosure access, and the information may not be protected by the federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department, Gulfport Memorial 4500 13th Street, Gulfport, MS 39501, Phone: 228-865-3172 or Privacy Officer at 228-865-3178.

____ ____
Signature of Patient or Legal Representative Date

____ ____
If signed by Legal Representative, Relationship to patient Signature of Witness

For individuals requesting his/her own health information, please use: Patient Request to Access Health Information Form