

South Mississippi Psychiatric Group/Pine Grove Outpatient Services

An Extension of Forrest General Hospital

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

South Mississippi Psychiatric Group/Pine Grove Outpatient Services
An Extension of Forrest General Hospital
1 Lincoln Parkway, Suite 202
HATTIESBURG, MS 39402

Section A: Must be completed for all authorizations

Patient Name:
Address:
Telephone:

Date of Birth:
Soc. Sec. #
Med. Rec. #
Account #:

I hereby authorize SMPG/Pine Grove Outpt Services to disclose to the following information.

This information is to be disclosed for the purpose of:

Covering the period (s) of healthcare: From (date) to (date)
(please state who the medical information should be released to, including their address and the purpose of disclosure)

Information to be disclosed: (check all that apply)

- Entire Health Record(s)
History & Physical
Laboratory Tests
ER Record (s)
Billing Information
Discharge Summary
Operative Report
X-ray Reports
Outpatient Record
Incomplete Record

I understand that this will include information relating to: (check if applicable)

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
Psychiatric Care
Treatment for alcohol and/or drug abuse

Other, please specify:

I hereby authorize SMPG/Pine Grove Outpt Services to obtain from the following information.

This information is to be obtained for the purpose of:

Covering the period (s) of healthcare: From (date) to (date)
(please state who the medical information should be released to, including their address and the purpose of disclosure)

Information to be disclosed: (check all that apply)

- Entire Health Record(s)
History & Physical
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I understand that this will include information relating to: (check if applicable)

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
Psychiatric Care
Treatment for alcohol and/or drug abuse

Other, please specify:

Section B: Must be completed for all authorizations.

The patient or the patient's representative must read and initial the following statements:

- 1. I understand that this authorization will expire on (Month/Day/Year)
2. I understand that I may revoke this authorization at any time by notifying Forrest General Hospital in writing, but if I do it won't have any affect on any action Forrest General Hospital took before they received the revocation.
3. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

Section C: Must be completed only if Forrest General Hospital has requested the authorization for its own use or disclosure, or for a disclosure from another health care provider or health plan.

- 1. Forrest General Hospital must complete the following:
Will Forrest General Hospital receive financial or in kind compensation in exchange for using or disclosing the health information described above? Yes No

- 2. The patient or the patient's representative must read and initial the following statements:
a. I understand that my health care and the payment for my healthcare will not be affected if I do not sign this form.
b. I understand that I may see and copy the information described on this form if I ask for it, and that I can get a copy of this form after I sign it.

(form must be completed before signing)

Signature of patient/patient's representative:
Printed name of patient's representative:
Relationship to the patient:
Date:

Witness (Signature needs to be witnessed by someone other than a family member)

This information has been disclosed to you from the records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR, Part 2) prohibits you from making further disclosure of it without the specific consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient.

SWORN TO AND SUBSCRIBED BEFORE ME, THIS DAY OF

My Commission Expires:

Notary Public