AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

revised.09/13/16

Patient's Name:_____ Date of Birth: _____
Social Security Number:_____ Health Record Number: _____

I, the undersigned, hereby authorize (Covered Entity)_____,
whose address is _____ to disclose the following protected health information (PHI) from the medical records of the patient listed below to:

DENSON AND ASSOCIATES, PLLC
POST OFFICE BOX 5022
1931 TWENTY-THIRD AVENUE
MERIDIAN, MISSISSIPPI 39302-5022

Disclose the following PHI for treatment dates _____ to _____.

☐ Abstract/Pertinent	☐ History & Physical	☐ Discharge Summary
☐ Operative Report	☐ Progress Notes	☐ Physician Orders
☐ ER Report	☐ Lab results	☐ X-ray and imaging reports
☐ Consultation report	☐ Nurses Notes	☐ Entire Chart/Record
☐ Discharge Instructions/After Visit Summary	☐ Pathology Reports	☐ Cardiology
☐ Clinic visits	☐ Hospital Admission	

☐ Other Specified: _____
_____

The above information is disclosed for the following purposes:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other _____

_____ ***Initials*** I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This authorization shall expire upon this expiration date: _____

** If I fail to specify an expiration date or event, this authorization will expire one (1) year from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released prior to this authorization.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I understand that the covered entity may not condition my treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization or the consequences to the individual of a refusal to sign the authorization.

I have read the above and authorize the disclosure of the protect health information as stated.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
If signed by legal representative, relationship to patient Signature of Witness