Liberty Heart Center
3491 Bluecutt Road Suite 3 Columbus, MS 39705
Phone: (662) 241-0050 Fax: (662) 241-7747

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT'S NAME_____ BIRTHDATE _____ SSN _____
ADDRESS_____
I authorize Dr. J. Barton Williams OR (specify if applicable)_____ to:
☐ **disclose** my health information *to*:_____
(name and address)-Specify: Attorney, Insurance, Self, etc.

☐ **obtain/request** copies of my health information *from*:_____
(name and address)-Specify: Hospital, Doctor, etc.
Purpose of use, disclosure, and or request: ☐ Continuation of Care/Treatment ☐ Attorney
☐ At the request of patient ☐ Payment ☐ Other, specify:_____

I authorize use and/or disclosure of information covering treatment from _____ to _____
(specify dates)
Information to be used and/or disclosed:
☐ Abstract (example: History and Physical, Discharge Summary, Operative Report, and Pathology Report)
☐ Itemized Bill ☐ Radiology Film ☐ Emergency Department Record
☐ Other (Specify) _____ ☐ All

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or (AIDS).

This authorization will expire 90 days from the date of your signature unless you specify a different expiration date, event, or condition.
Please Specify: _____

I understand that I have a right to revoke this authorization at any time, except to the extent that release of information has already occurred in reliance on my prior authorization.
I understand that in order to revoke an authorization, a written document stating the intent of the patient is to be either delivered in person or by certified mail to the facility indicated above. The revocation document is to contain the signature of the patient or patient's legal representative.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, if this authorization is for release of records to a third party for payment, enrollment or eligibility or benefits purposes, such as workers' compensation, private health insurance, application for insurance, etc., my refusal to sign may effect payment, enrollment or eligibility for benefits. This, in turn, may effect payment for services I receive and I may become responsible for all charges incurred. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.

I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

When Dr. J. Barton Williams **seeks** an authorization for its own use or disclosure of protected health information (e.g., marketing, research, etc.) a **copy** of the authorization is provided to the patient.
Date_____ Patient_____
Witness_____ Person acting for patient_____