HINDS MEDICAL GROUP, A PROFESSIONAL CORP

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: ____
(First Name) (Middle Initial) (Last Name)

Address: ____

Date of Birth: ____

Hinds Medical Group is authorized to **furnish to / receive from** (circle desired choice):

Recipient/Discloser: ____

For the Purpose of : ____
(optional)
____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

- ❑ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

- ❑ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:
____
____

I release Hinds Medical Group, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Hinds Medical Group, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ____/____/____ *(Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

______________________________ ______________________________
Patient Signature (Parent's Representative if minor) Date

______________________________ ______________________________
Witness Signature Date

So that we may improve our patient care, please let us know the reason you are requesting this record release (check all that apply):

- ❑ Not satisfied with Provider (which provider? ____________________)
- ❑ Not satisfied with Staff (which staff member? ____________________)
- ❑ Moving out of the area?
- ❑ Other (Please describe :________________________________)