Mississippi Sports Medicine
And Orthopaedic Center

499 Gloster Creek Village, Ste G1, Tupelo, MS 38801 • Phone: 662-377-2663 • Fax: 662-377-6706
www.mississippisportsmedicine.com

Patient Name: _____ Date of Birth: _____ Chart #: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with Mississippi State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that:

1. This authorization may include disclosure of health information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT (except psychotherapy notes), and CONFIDENTIAL HIV RELATED INFORMATION.
2. You have the right to inspect, copy, and/or amend information to be used or disclosed.
3. I have the right to revoke this authorization at any time by writing to the privacy officer. I understand that I may revoke this authorization except to the extent that action has already been taken based on the authorization.
4. You may refuse to sign this form; however, it may prevent us from completing a task you have requested (such as enrollment in research study or examining you to create a report for your attorney).
5. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
6. Information disclosed under this authorization might be disclosed by the recipient, and this disclosure may no longer be protected by federal or state law.
7. We must provide you with a copy of this authorization form upon request.

Name and address of health provider or entity to release this information:

_____

Name and address of person(s) or category of person to whom this information will be sent:

_____

a. Specified information to be released:
    - Medical Records from _____ to _____
    - Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
    - Other: _____

Authorization to Discuss Health Information

a. By initialing here _____ I authorize Mississippi Sports Medicine & Orthopaedic Center to discuss my health information with the above listed agency.

Reason for release of information:

- At request of individual
- Other

Date or event on which this authorization will expire:

_____

If not the patient, name of person signing form:

_____

Authority to sign on behalf of patient:

_____

I have carefully read and understand the above and do herein expressly and voluntarily authorize the disclosure of the above information or medical records about my condition to those people or agencies listed above. I understand that even if I do not withdraw the authorization that this authorization will expire one (1) year from this date.

_____ _____

Signature Date