NORTH MISSISSIPPI MEDICAL CENTER(S) and CLINIC(S)

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Patient Name_____

Address _____

Patient Social Security Number _____

Date of Birth_____ Phone Number _____

Date (s) of Service _____

Describe information to be used or disclosed):_____

_____

_____

I authorize _____ to use or to disclose my individually

(Name of Person or Organization authorized to use or disclose information)

identifiable health information as described above to

_____

(Name of person or organization authorized to receive information)

_____

mailing address City State Zip Code phone number

for the purpose of:

_____

_____

NOTICE TO PATIENT: You or your authorized representative may inspect and/or obtain a copy of health information to be
used or disclosed as permitted under state or federal law in accordance with NMMC's policies.

There will be a cost for copies. Fee schedule available upon request.
I understand that I may revoke this authorization by signing a Revocation of Authorization form and returning it to NMMC.
To request a Revocation of Authorization form, I may contact:

North Mississippi Medical Center(s) and Clinics
830 S. Gloster St. Tupelo, MS 38801

Attn: Record Custodian

I understand that if I revoke this authorization, my revocation will not have any effect on actions which NMMC
took in reliance upon my authorization before it received my revocation.

I understand that NMMC will not condition my treatment or payment for health care services on my completing and signing this authorization.

I understand that the organization authorized to receive the information may also disclose my health information and that my information may no longer be protected by federal privacy regulations.

This authorization will expire _____ (specific date/event required).

_____ Date: _____

(Signature of patient or patient's representative)

Representative's authority_____

NOTE: This authorization may not be used for research purposes.
Effective April 14, 2003