Authorization for Release of Medical Records

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____

_____ I hereby authorize Children's of Mississippi/NMMC Children's Clinic to release information from the medical record of the patient listed above by mail or fax to:

_____ I hereby authorize the following to release information from the medical record of the patient listed above by mail or fax to Children's of Mississippi/NMMC Children's Clinic, 830 South Gloster Street, Tupelo MS 38801 (662-377-1399 fax).

Clinic or Facility: _____

Address: _____

Phone / Fax: _____

Please send the following information:

_____ Entire Chart Other: _____

Purpose of Disclosure (Please Circle):

Changing Physicians Consultation/Second Opinion Continuing Care Legal School Insurance

Other _____

I understand the documents authorized to be released by me include, but are not limited to, family histories, medical histories, reports of clinical findings and all diagnoses, laboratory test results, X-rays, reports of examinations and/or evaluations and any hospital admission or discharge reports. In the case the patient is a minor child, I confirm that my parental rights have not been terminated. I understand that I may revoke this authorization at any time by notifying Children's of Mississippi/NMMC Children's Clinic in writing, and it will be effective on the date notified except to the extent action has already been taking in reliance upon it. I understand that if the organization to whom I authorize release of information is not a health plan, health care provider or clearing house, the released information may no longer be protected by federal privacy regulations.

I understand this authorization will expire in 90 days or on _____.

Parent or Legal Guardian of Above-Listed Patient: _____

Relationship to Patient: _____ Date: _____

ALL RECORDS OVER 20 PAGES MUST BE MAILED TO THE ABOVE ADDRESS AND NOT FAXED UNLESS OTHERWISE REQUESTED.