Medical Record Number: _____

SE Lackey Memorial Hospital and Clinics

Patient Access/Authorization for Use and Disclosure of Patient Information

** Forms that are not complete will not be accepted. **

Please select the location for which you authorize to release your protected health information (PHI).

❑ **SE Lackey Memorial Hospital** ❑ **Nursing Convalescent Home**

❑ **Lackey Behavioral Health Unit:** _____ ❑ **Clinic/Other** (specify):_____

I hereby request/authorize the use or disclosure of my protected health information ("PHI") as described below.

Patient Information

Patient Name:_____ DOB: ___/___/____ SSN: _____

Address: _____ Phone: _____

City/State/Zip:_____

Release Information

Release to: _____ Release from:_____

Address: _____ Address: _____

City/State/Zip:_____ City/Sate/Zip:_____

Phone:_____ Phone: _____

Fax: _____ Fax: _____

Purpose of Release

❑ Personal ❑ Legal/Attorney ❑ Insurance ❑ Disability ❑ Continuing Care ❑ School

❑ Worker's Compensation ❑ Other *(be specific):* _____

PHI to be Released

Service Dates: From ___/___/____ To___/___/_____ **Information Needed By (optional):** ___/___/_____

❑ History & Physical ❑ Radiology Reports / Disk ❑ Consultation Reports ❑ Physician Orders

❑ Operative Report ❑ Electrocardiogram ❑ Emergency Room Report ❑ Progress Notes

❑ Entire Medical Record ❑ Discharge Summary ❑ Laboratory Reports

❑ Other: _____

***Sensitive Information Release:* I understand that this health information may include sensitive information. By signing this form, I specifically authorize the release of each *initialed* sensitive information item:**

____ Substance Abuse Treatment Information ____ Mental Health Information ____ Genetic Testing

____ HIV related information (including AIDS related testing) ____ Other abuse _____

Patient's Rights

This authorization will *expire 30 days from the date of signature*. I understand that when I give my permission to release my health information or take my permission away (revoke) from another facility or person, I must contact that party. **If you wish to take your permission away, please send a written notice with signature and date of patient information that was to be released to: SE Lackey Memorial Hospital, Attention: Health Information Department, 330 N Broad Street, Forest, MS 39074.** The notice should include detailed information as identified in the original authorization request. I understand that information used or disclosed pursuant to this authorization *may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations*. I understand this form is voluntary and *SE Lackey Memorial Hospital will not condition my treatment on giving this authorization*. I understand that I am entitled to receive a copy of this form after I sign it. I have carefully read and understand the Patient's Rights above, and do herein expressly and voluntarily authorize the disclosure of all the information requested in this authorization including the "Sensitive Information Release". **I acknowledge this authorization with my signature below**

_____ _____ ____/____/_____

Signature of Patient/Representative Description Date

_____ ____/____/_____

Witness Date

*** If this form is being signed on the behalf of a patient's representative, the person signing must document relationship above.*

***If the patient listed above is under the age of 18, this authorization form (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the behalf other minor. As the person signing for the patient, I, the parent, guardian, party acting as loco parentis, or legal representative warrant that I have the legal authority to act on behalf of the patient and that I am not prohibited by Court order or law from having access to the requested medical records.*