MISSISSIPPI ASTHMA & ALLERGY CLINIC, P.A.
1513 LAKELAND DRIVE, SUITE 101
JACKSON, MS 39216
FAX (601) 354-2619

Authorization for Disclosure of Health Information

1. I hereby authorize ________________________ to disclose the following information from the health records of:

   Patient Name ________________________ Date of Birth ________________________

   Address ________________________ Telephone ________________________

   ____

   Patient Number ________________________

   Covering the period(s) of health care

   From (date) ________________________ to (date) ________________________

   From (date) ________________________ to (date) ________________________

2. Information to be disclosed:

   - ❑ complete health record(s)
   - ❑ history & physical examination
   - ❑ consultation reports
   - ❑ X-ray reports
   - ❑ other (please specify)
   - ❑ discharge summary
   - ❑ progress notes
   - ❑ laboratory tests
   - ❑ photographs, videotapes digital or other images

   ____

I understand that this will include information relating to (check if applicable):

- ❑ acquired immunodeficiency syndrome (AIDS)
- ❑ human immunodeficiency virus (HIV) infection
- ❑ behavorial health service/psychiatric care
- ❑ treatment for alcohol and/or drug abuse

3. This information will be disclosed to ________________________

   For the purpose of ________________________

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

   ____

5. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

   Signed: ________________________ (Patient) Date ____________

   ________________________ (or legal representative) Date ____________

   ________________________ (relationship to patient)

   Signature of Witness: ________________________ Date ____________