

MISSISSIPPI ASTHMA & ALLERGY CLINIC, P.A.
1513 LAKELAND DRIVE, SUITE 101
JACKSON, MS 39216

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:

- | | |
|---|--|
| <input type="checkbox"/> complete health record(s) | <input type="checkbox"/> discharge summary |
| <input type="checkbox"/> history & physical examination | <input type="checkbox"/> progress notes |
| <input type="checkbox"/> consultation reports | <input type="checkbox"/> laboratory tests |
| <input type="checkbox"/> X-ray reports | <input type="checkbox"/> photographs, videotapes |
| <input type="checkbox"/> other (please specify) | 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
- behavioral 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 _____