MISSISSIPPI
**Asthma
&Allergy
Clinic** P.A.

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)   ❑ discharge summary

       ❑ history & physical examination   ❑ progress notes

       ❑ consultation reports   ❑ laboratory tests

       ❑ X-ray reports   ❑ photographs, videotapes

       ❑ 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

       ❑ 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_____

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