PATIENT AUTHORIZATION
FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION
TO THIRD PARTIES
(Sending TO Children's Medical Group)

- **USE THIS FORM TO HAVE HEALTH INFORMATION SENT TO CHILDREN'S MEDICAL GROUP.**
- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM; HOWEVER, IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED.**
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION.**
- **WE WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

_____
Date of Request

_____ _____
Patient Name Date of Birth

_____
Patient Address

_____
Physician to provide records

By signing this authorization, I authorize _____ (health care provider name) to use and/or disclose certain protected health information (PHI) about me/my child to Children's Medical Group.

Send to: ☐ Children's Medical Group - Clinton
539-C Hwy 80 West
Clinton, MS 39056
Phone (601) 362-8776
Fax (601) 924-0988

☐ Children's Medical Group - Jackson
1867 Crane Ridge Dr, Ste 101B
Jackson, MS 39216
Phone (601) 362-8776
Fax (601) 354-8786

☐ Children's Medical Group - Madison
7726 Old Canton Road
Madison, MS 39110
Phone (601) 362-8776
Fax (601) 856-8637

I understand this authorization is at my request and this authorization permits _____ (health care provider name) to disclose to Children's Medical Group the following individually identifiable health information. I understand this may contain treatment notes regarding radiology, pathology ***including HIV test results and genetic testing information***, immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2***, and other common medical record documentation made by the physician, nurse or other ancillary personnel.

Release these records: (Select only one) **Initials**

1. Only records generated by the health care provider (not including records from other sources) _____
2. All medical records maintained by the health care provider including records from other clinics/doctors _____
3. Only some portion of records maintained by the health care provider (date of treatment, etc. - specify below) _____

For #3 above, please indicate dates of treatment for which medical information is needed for release, or specific forms: (ex. Vaccination records, camp health forms, sports participation, school or work excuses, school medication administration forms, or college health admission forms)

_____

_____

_____

_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to Children's Medical Group with the **exception** of: (Please initial exception)

_____ Substance abuse, if any _____ Psychological or psychiatric conditions, if any

_____ AIDS/HIV, if any _____ Other (specify)_____

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

When my or my child's information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that CMG has acted in reliance upon this authorization. My written revocation must be submitted to Children's Medical Group, P.A.'s Privacy Officer at 1867 Crane Ridge Drive, Suite 101B, Jackson, Mississippi 39216.

Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original.

_____ _____

Person Authorized to Sign for Patient (Please print) Relationship to Patient
[Patient name if 18 years or older]

_____

Phone #

X_____ _____

Signature of Authorized Person Date
[Patient must sign if 18 years or older]