AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Date:___________________________

Physician to provide records:____

Patient's full name:____ Date of Birth:_____________________

Address:____

____

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

☐ __________________________________
____
____

Release these records: (Select only one) Initials

1. All medical records maintained at this facility including records from other sources ______
2. Only records generated by this facility (not including records received from other sources) ______
3. Only some portion of records maintained at this facility (Specify below) ______

   Dates of Service:____

   Specific Conditions:____

   Other:____

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 the provider or individual listed above 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.

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

Person authorized to sign for patient (print name):____
(If patient is 18 years or older, he/she must sign this form.)

Relationship to patient:______________________________Telephone:_________________________________

Signature of authorized person:_______________________________________Date:________________________