Quitman County Hospital, LLC

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to use or disclose from the health records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone #:_____ Patient #:_____

Covering period(s) of health care:

From: _____ Date: _____ From: _____ Date: _____

From: _____ Date: _____ From: _____ Date: _____

The following information:

☐ Complete Health Record(s)

☐ Abstract health record(s) (H&P, Discharge Summary, Consultation, Reports, Operative & Procedure Reports, EKG(s), Laboratory, X-Ray, and imaging reports)

☐ Name & contact info
☐ History & Physical
☐ Laboratory tests
☐ Consultation reports
☐ Other (Specify) _____

☐ Diagnosis & Treatment
☐ Discharge Summary
☐ X-ray report(s)
☐ Progress Notes

Behavioral Health Reports:

☐ Social History
☐ Client Data Form
☐ Referral/Treatment Form
☐ Admission Evaluation
☐ Notification of Admission

☐ Treatment Plan
☐ Academic History
☐ Aftercare Instructions
☐ Psychological Evaluation
☐ Other (Specify)_____

To the following person or class of person(s)

_____

_____

Check (✓) one:
☐ For the following purpose(s)_____

_____

☐ At the request of the individual.

Check (✓) one:
This authorization expires on:

☐ _____ {date or event} _____

☐ End of research {only if use or disclosure is for research purpose}

☐ None {only if use or disclosure is for creation and maintenance of a research database or research repository}

I understand that the information in my record may include information related to sexually transmitted disease acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol/drug abuse.

We will condition your right to treatment or payment on your granting this requested authorization unless (1) your treatment is research-related and this authorization is for use or disclosure in connection with that research, or (2) the health care you will receive for the purpose of disclosure to a third party and this authorization relates to its disclosure to that third party.

You have the right to refuse to sign this authorization.

You have a right to inspect or copy the protected health information that will be used or disclosed by us. See our Notice of Privacy Practices for details.

Except to the extent that we have already relied on it, you have a right to revoke this authorization by doing so in writing address to the following:

Quitman County Hospital, LLC
340 Getwell Drive
Marks, MS 38646
Attn: Privacy Official
(662) 326-8031

{Revocation may be denied if your authorization was required in order to obtain and insurance policy and the insurer has a legal right to contest the policy or a claim under the policy.}

The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that require health care providers to protect individually identifiable health information.

If the use or disclosure for which authorization is being sought is for marketing purposes:
Use or disclosure ☐ will ☐ will not result in direct or indirect remuneration to us from someone else.

Date: _____

_____
Signature

{Provide a copy to the individual}

_____
Print Name

_____
Authority of Personal Representative
If signing for the individual

_____
Signature of witness

_____
Date