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# MEMORIAL HOSPITAL AT GULFPORT/
# MEMORIAL BEHAVIORAL HEALTH

## Authorization for Use and Disclosure of Health Information

Patient Name: _____ Medical Record No. _____

Patient Address: _____ Phone No.: _____

Date of Birth: _____ Social Security No.: _____

1. I authorize the following institution to use or disclose the above named individual's health information as indicated below:

Circle One: Memorial Hospital MBH Other (Name)

2. I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that after the above named facility discloses this information, it no longer has control over protection of the confidentiality of the information. Should the recipient redisclose the information, it will not longer be protected by Federal Privacy Regulations.

3. Dates of Service:

_____
_____
_____

Information to Release:

____ Discharge Summary
____ History / Physical
____ Admission Psychiatric Info
____ Consultation / Evaluation
____ Verbal exchange of info
____ Progress Notes
____ Operative Report
____ Lab / Path Report
____ Other: _____
____ Education Progress Rpt(s) Grade
____ X-Ray Report
____ Cardiology
____ ER Report

4. I understand that the information in my health record may include information relating to:

- Sexually transmitted diseases
- Acquired immunodeficiency syndrome (AIDS)
- Human Immunodeficiency Virus (HIV)
- Behavioral or mental health services
- Treatment for alcohol and drug abuse - protected by Federal Regulation 43 CFR Part 2

5. This information may be disclosed to and used by the following individual or organization:

Name: _____ Phone: _____

Address: _____

For the purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department as explained in Memorial Hospital's Notice of Privacy Practices. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition this authorization will expire in one year.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164, 524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Health Information Management Department, Memorial Hospital at Gulfport, 4300 Thirteenth St., Gulfport, MS 39502, Phone: 228-865-3172 or Privacy Officer at 228-865-3178.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

PATIENT INFORMATION

Memorial

Building a Healthier Community