MAGNOLIA REGIONAL HEALTH CENTER
One Patient at a Time.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____ SS # _____

Address _____ DOB _____

_____ Phone # _____

I *authorize* **Magnolia Regional Health Center** to release my Protected Health Information to:

Name and Address: _____

Method of Disclosure: ( ) Copy ( ) Access ( ) Fax # _____

( ) CD of Imaging ( ) Patient Portal: Email Address _____

Type of Request:

( ) Out-of-State Subpoena ( ) Non-Staff Physician ( ) Medical Care ( ) Personal

( ) Legal ( ) Health Insurance ( ) Other Insurance ( ) Workers Comp

Information Requested:

Date(s) of Service _____

( ) Chart Abstract ( ) Operative Reports ( ) Lab Reports/Path ( ) Outpatient Records

( ) History & Physical ( ) Consult Reports ( ) ER Reports ( ) Radiology Reports

( ) Discharge Summary ( ) Other (please specify) _____

This authorization will expire in **90 days** from the date of my signature. I understand that I have a right to revoke this authorization at any time, in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from MRHC.

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

Signature of patient _____ **Date** _____

OR

Signature of patient representative _____ **Date** _____

POA ( ) Yes ( ) No ( ) On file

Under Federal HIPPA regulations, MRHC is generally required to allow patients access to and copies of their records within 30 days and may charge patients for the cost of copying and sending the records. Any direct access will be under direct supervision by HIM personnel or designee.

MRHC USE ONLY Account # _____ Unit # _____

Identification Verified by ( ) Signature ( ) Picture ID

Person Receiving Request _____ Date _____

Copy / Access Granted ( ) Date _____

Copy / Access Delayed ( ) Date Notice Given _____

Access Denied ( ) Date _____

Reason for Denial

( ) Health care professional determination ( ) Research in process

( ) Administrative Decision ( ) Other _____

Original for patient's record / Copy to patient/requester

Return completed form to the HIM Department or fax to (662) 293-4241 or call (662) 293-1255 or mail to MRHC, ATTN. HIM Dept., 611 Alcorn Dr. Corinth, MS 38834.