CARDIOLOGY ASSOCIATES OF NORTH MISSISSIPPI, P.A.

801 Stark Road
Starkville, MS 39759

499 Gloster Creek Village, Suite A-2
P.O. Box 2519
Tupelo, MS 38803-2519

2892 South Lamar
Oxford, MS 38655

2459 5th Street North
Columbus, MS 39785

Please return medical request to the above P.O. Box, Tupelo, MS location, attention Medical Records.

Authorization To Release Medical Records

PATIENT IDENTIFICATION:

Patient Name: _____ S.S.#_____
Last First M.I.

Address: _____ Phone No.:_____
Street (area code)

_____ Date of Birth:_____
City State Zip Code

MEDICAL RECORDS ARE TO BE SENT TO:

Name of Person or Place:_____ Phone No.:_____

Address:_____ Fax Number:_____
Street City State Zip Code

TO BE USED FOR THE PURPOSE OF: _____ Disability _____ Insurance _____ Attorney

_____ Personal Use _____ Continued Treatment _____ For Another Physician _____ Other

INFORMATION TO BE RELEASED:

I, the undersigned, hereby authorize and request Cardiology Associates of North Mississippi, P.A. to release information regarding my medical records for the purpose of review and examination and further authorize and request that you provide such copies as requested. The foregoing is scheduled to such limitation indicated below:

MUST BE COMPLETED:

Confined to the following specific information or specific period of records _____

_____

MUST BE INITIALED:

No limitations placed on dates, history of illness, or diagnostic and therapeutic information, including the treatment for psychological or psychiatric impairment, drug abuse and/or alcoholism, or Acquired Immunodeficiency Syndrome or test for or infection with Human Immunodeficiency virus.
Patient Must Initial Here For Authentication Of This Response._____

Signature of patient:_____ **DATE:**_____
If signed by personal representative, state relationship and authority to do so. _____

_____

NOTE TO RECIPIENT(S) RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected. Statutes/Regulation prohibit you from making further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

(Revised 8/01/11) **PLEASE SEE BACK OF FORM** CARD 51

Authorization To Release Medical Records
Continued

Check one:

( ) This authorization expires on: sixty days from date of signature

( ) End of research (only if use or disclosure is for research purposes).

( ) None (only if uses or disclosure is for creation and maintenance of research database or research repository).

We will not 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 is for the purpose of disclosure to a third party and this authorization relates to its disclosure to that third party.

You have a right to refuse to sign this authorization.

You have a right to inspect or have a copy of 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 addressed to the following:

Cardiology Associates of North Mississippi, P.A.
P.O. Box 2519
Tupelo, MS 38803-2519
Attn: Privacy Officer

(Revocation may be denied if your authorization was required in order to obtain an 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 the 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 of disclosure ( ) will (X) will not result in direct or indirect remuneration to us from someone else.

Patient Signature:_____ **Date:**_____

Print Patient Name:_____

_____
Authority of Personal Representative, if signing for the Individual.

Provide a copy to the Individual

CARDIOLOGY ASSOCIATES OF NORTH MISSISSIPPI, P.A.

INDIVIDUAL REVOCATION OF AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION

I, _____, hereby revoke an authorization dated _____(use approximate date if date of authorization unknown) to use or disclose individually identifiable health information about me except to the extent that action has been taken in reliance on that authorization. If the authorization was obtained as a condition of my obtaining insurance coverage, I understand that this revocation is effective only to the extent that other law provides the insurer with the right to contest a claim under the policy.
Date: _____ Patient Signature: _____ Patient Identifier: _____

Address:_____ Telephone Number: _____