Cardiology Associates of North Mississippi

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name (Print):_____ **Date of Birth**:_____

Social Security Number (last 4 digits): xxx-xx-_____ **Primary Contact Number:**_____

Patient's Mailing Address: _____

I hereby request access to my medical records held by:_____
[Name of Hospital/Clinic/Physician Office]

Purpose of Release: ☐Continuum of Care or ☐Other (specify):_____

Protected Health Information (PHI) to be released: (please check below): **Date(s) of Service**:_____

☐ Complete Medical Record	☐ History and Physical(s)	☐ Discharge Summary	☐ Consultation Report
☐ Operative/Procedure Report	☐ Lab Results	☐ Radiology Reports	☐ Radiology Films
☐ Clinic Progress Notes	☐ ER Record	☐ Pictures	☐ Pathology Slides*

☐ Other:_____ *Please note: The HIM department is not responsible for pathology slides. To obtain these, please send your request to the department that performed your tests.

I understand that information released pursuant to this request may include information relating to Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

Form and Format of the Release:
I understand that I have the right to receive my health information in the form and format of my preference to the extent my information is held in electronic form and NMHS is capable of fulfilling the request. I also understand that I may request my information to be sent via unencrypted email or to my unsecure email account. By choosing that type of format, I accept the fact that my information may be at risk of being read or accessed by someone else.

☐ Paper(Default) ☐Password Protected CD/USB Drive ☐Patient Portal ☐Clinic ☐Hospital

☐ Secure E-mail ☐ Unsecure E-Mail ☐Other:_____

Designated Individual to Receive the records: ☐ Self or ☐Authorized Representative

CONTACT INFORMATION FOR RECIPIENT: (Full Name, Address, and Phone Number): (E-mail address):	FOR OFFICE USE: Scribed/documented by HM Staff Member: Initials: _____ [Original patient request made on alternate form. (See attached)]

NOTICE TO PATIENT: You or your authorized representative may inspect and/or obtain a copy of health information to be used or disclosed as permitted under state or federal law in accordance with CANM's policies. There will be a cost for copies. Fee schedule available upon request.

I authorize the release of health information as described above.

_____ _____
Signature of Patient or Qualified Personal Representative Date

If signed by a Qualified Personal Representative, the following must be completed:

Printed name of Qualified Personal Representative:_____

Legal Authority to Act on Behalf of the Patient: _____
[Example: Patient, Guardian, Executor of Estate]

I understand that I may revoke this authorization by signing a Revocation of Authorization form and returning it to CANM. To request a Revocation of Authorization form, I may contact: ***Cardiology Associates of North Mississippi, 499 S Gloster St. Suite A-2, Tupelo, MS 38801 Attn: Record Custodian***

I understand that if I revoke this authorization, my revocation will not have any effect on actions which CANM took in reliance upon my authorization before it received my revocation. I understand that CANM will not condition my treatment or payment for health care services on my completing and signing this authorization. I understand that the organization authorized to receive the information may also disclose my health information and that my information may no longer be protected by federal privacy regulations.

This authorization will expire **in 30 days** unless otherwise specified as: _____ (specific date/event). Patient Initials _____