FIELD HEALTH SYSTEM
Your Home for Health and Wellness

178 Hwy 24
CENTREVILLE, MS 39631
Phone:601-890-0500
Fax: 601-645-5873

Authorization to Use, Disclose or Release of Protected Health Information

I hereby authorize **FIELD HEALTH SYSTEM** to release (or retain) protected health information (PHI) from the medical records of the patient listed below to (or from).

Patient's Name: _____ Telephone Number: _____

Patient's Date of Birth: _____ Patient's Soc. Sec. #:_____

Patient's Address**:** _____

_____

Requestor Name: _____Telephone Number: _____

Requestor Address**:** _____

_____

Disclose of the following PHI for Treatment from _____ to _____

☐Entire Chart ☐History and Physical reports ☐Discharge Summary ☐Consultation

☐Operative Reports ☐Progress Notes ☐Emergency Room Records ☐Lab ☐EKG

☐X-Ray ☐ Other Specified: _____

This information for which I am authorizing disclosure will be used for the following purpose:

☐Medical Care ☐Legal ☐Insurance ☐Personal ☐ Other Specified: _____

I understand that any disclosure of records concerning diagnosis and/or treatment related to alcohol and/or drug abuse is covered by Title 42 of the Code of Federal Regulations. If my records contain information governed by Title 42 of the Code of Federal Regulations, I authorized the release of such information as indicated above**._____ (initial)**

This authorization shall also include any information related to the diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the Human Immunodeficiency Virus (HIV) (AIDS VIRUS)._____ **(initial)**

This authorization shall expire upon expiration of **(1) year** from the date signed below. _____

******If I fail to specify an expiration date, this authorization will expire (6) six months from the date signed below. ******

I understand that I have a right to revoke this authorization at any time. I understand that I must do so in writing and present my written revocation to the Health Information Department Director or Release of Information representative. I understand that the revocation will not apply to information that has already been released in response to this authorization.
I understand that the information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected.
I have read the above statements and hereby authorize the disclosure of the protected health information as seated. The hospital is hereby released and discharged of any liability and the undersigned will indemnify and hold the hospital harmless for complying with this authorization.

Signature of Patient or Legal Representative: _____

Date: _____

If signed by Legal Representative, relationship to patient: _____

Signature of Witness _____ Date _____