



Post Office Box 948
427 Highway 51 North
Brookhaven, MS 39602-0948
Telephone (601) 833-6011

Authorization for Release of Health Information

I hereby authorize King's Daughters Medical Center the use or disclosure of the below named individual's health information as described below.

Form fields for Patient Name, Date of Birth, SS #, Address, and City, State, and Zip Code.

Dates of Service

Information to Be Used or Disclosed:

- Copy of complete hospital records
Copy of complete physician's office records
Discharge Summary
History and Physical
Operative Report
Emergency Room Report
Diagnostic Studies (Lab, X-rays, EKGs, etc)
Other

Information to Be Disclosed to:

Name/Address

Purpose of Disclosure:

- Further Treatment
Insurance Requested
Attorney
Other

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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. 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 . If I fail to specify an expiration date, this authorization will expire 6 months.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at this facility.

Form fields for Date, Patient or Representative's Signature, Relationship to Patient, Date, and Witness' Signature.