Primary Care Plus
a service of St. Dominic's

PATIENT ACCOUNT #_____

AUTHORIZATION FOR RELEASE OF MEDICAL PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Full Name _____ Street Address _____

DOB _____ SSN _____ City, State Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

ENTITY RELEASING RECORDS

Name _____

Street Address _____

City, State Zip _____

Phone # _____ Fax # _____

ENTITY RECEIVING RECORDS

Name _____

Street Address _____

City, State Zip _____

Phone # _____ Fax # _____

PURPOSE OF RELEASE

☐ Personal ☐ Legal ☐ Insurance ☐ Disability

☐ Other (describe below) ☐ Continuity of Care

_____
(description of other purpose of release)

FORMAT OF RELEASE

☐ Paper ☐ CD ☐ E-mail ☐ Fax

_____
e-mail address

PROTECTED HEALTH INFORMATION TO BE RELEASED

☐ Entire Medical Record ☐ Progress Notes ☐ Consult Notes ☐ Physicals

☐ Lab Reports ☐ Radiology Reports ☐ X-Ray Images ☐ Immunization Record

☐ Other: _____

☐ Confined to records regarding treatment for the following medical condition / injury:

_____
(description of medical condition / injury)

Service Dates: ____ (Month) / ____ (Day) / ____ (Year) to ____ (Month) / ____ (Day) / ____ (Year)

Expiration Date: ____ (Month) / ____ (Day) / ____ (Year) ***If none listed, this authorization will expire six (6) months from date of signature.*

I understand, and hereby consent that the released information may contain, but is not limited to, information concerning STD's, drug/alcohol use, HIV (AIDS), mental health, and genetic testing.

PATIENTS RIGHTS

The undersigned hereby authorizes and requests MEA Primary Care Plus to release information regarding my medical records for the purpose of review and examination and further authorize and request that MEA Primary Care Plus provide such copies as requested. I understand that the information described above may be subject to redisclosure by the recipient and no longer protected by federal privacy regulation. I understand this form is voluntary and the covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, by submitting such request to the following: **MEA Primary Care Plus**, **Attn: Privacy Officer**, **308 Corporate Drive**, **Ridgeland, MS 39157**

Signature of Patient / Personal Representative _____ Date _____

****If signed by personal representative instead of patient, fill out the following information *(documentation must be provided)***

☐ Parent ☐ Guardian ☐ Executor of Estate ☐ Healthcare Power of Attorney

Name of Personal Representative (please print) _____ Relationship to Patient _____