**MEA PRIMARY CARE PLUS**

**Authorization for Release of Protected Health Information (PHI)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: | | Birth Date: | Patient’s Address:  (city, state, zip) | | | |
| Patient’s Phone Number: | | Patient’s Email Address: | | Last 4 Digits of Social Security Number: | | |
| Requester’s Name: | | | Requestor’s Relationship to Patient: | | | |
| **Purpose of Disclosure**  ❑ Medical Care ❑ Legal ❑ Insurance ❑ Personal ❑ Other | | | | | | |
| **Description of Information to be Used or Disclosed** | | | | | | |
| Is this request for psychotherapy notes?  ❑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.  ❑ No, then you may check as many items below as you need. | | | | | | |
| Information to be disclosed: | | | | | | |
| ❑ After Visit Summary (AVS) | ❑ History & Physical Exam | | ❑ Operative Report | | ❑ Itemized Bill | |
| ❑ Laboratory Report | ❑ Radiology Report | | ❑ Consultation | |  | |
| ❑ Pathology Report | ❑ EKG | | ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Date of Service: \_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_ Date of Service: \_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_ Date of Service: \_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_ | | | | | | |
| The following information will be released when included in the above unless you indicate otherwise:  ❑ Do not release any AIDS or HIV test results ❑ Do not release any records of psychiatric care  ❑ Do not release any records of alcohol/drug abuse ❑ Do not release records of genetic testing | | | | | | |
| Individual or Entity Authorized to **DISCLOSE** Information: | | | Individual or Entity Authorized to **RECEIVE** Information: | | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 1. I understand that this authorization is voluntary and that I may refuse to sign per the Health Insurance Portability and Accountability Act (HIPAA). 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I may get a copy of this form after I sign it. | | | | | | |
| **I have read the above and authorize the disclosure of the protected health information as stated.** | | | | | | |
| Signature of Patient or Legal Representative: | | | Date: | | | Time: |
| Print Name of Patient or Legal Representative: | | | Relationship to Patient or Legal Representative: | | | |
| This authorization shall expire on this expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*\* If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed. \*\* | | | | | | |

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308 Corporate Drive

Ridgeland, MS, 39157