**MEA PRIMARY CARE PLUS**

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

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| 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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