Authorization to Release/Disclose Medical Information

Patient Name: ____ Patient Birthdate: ______________

Current Address:____

City, State, Zip: ___________________________Phone #: ___________________ SS #: ________________

ENTITY RELEASING/DISCLOSING MEDICAL RECORDS (Physician and/or Facility):

I HEREBY AUTHORIZE: _________________________________ Phone #: ____________ Fax #: ____________

Address: ____City, State, Zip: ___________________________

ENTITY RECEIVING MEDICAL RECORDS (Physician and/or Facility):

TO RELEASE TO: ______________________________________ Phone #: ____________ Fax #: ____________

Address: ____City, State, Zip: ___________________________

INFORMATION TO BE RELEASED: I am requesting the private health information for treatments dates:

_____ (ALL) **or** from: ____________ (date) to: ____________ (date).

INFORMATION REQUESTED (Check all that applies):

- History and Physical
- Discharge Summary
- Operative Report
- X-Ray/Imaging
- Lab
- Physician Orders
- Clinic Visits
- Cardiac Test
- EKG
- Lab
- All information

I understand that this consent will expire **sixty days from date of signature.** Except to the extent that we have already relied on it, you have a right to revoke this authorization by doing so in writing to the Privacy Officer of Jackson Heart Clinic, P.A. (970 Lakeland Drive Suite 61 Jackson, MS 39216).

Patient signature:____ **Date:**_______________

If signed by representative/guardian:

Signature of representative/guardian: ____

Authority to sign for Patient:____ **Date:**_______________

Signature of Witness:____ **Date:**_______________