106 Strange Road
Starkville, MS 39759
Phone: 662-268-5042
Office: 662-338-3128

AUTHORIZATION FOR DISCLOSURES OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Patient Number: _____

Date of Birth: _____

I hereby authorize _____ to use or disclose my protect health information covered under privacy regulations issued pursuant to the HIPAA of 1996 to: _____

For the following purposes: _____

List the information to be used or disclosed: _____

_____

_____

❑ I hereby authorize/grant _____ to have access to my medical records anytime and/or when necessary.

CONDITIONS:

The patient agrees to authorize the above named individuals/organization to access his/her confidential healthcare information only for the purpose listed above.

The information authorized to be released will not be covered under the federal privacy laws.

The Huxford Clinic will provide the patient with a copy of the confidential healthcare information for which this authorization is being sought.

The patient is voluntarily signing this authorization

The patient reserves the right to revoke this authorization at any time. This revocation must be in writing and shall not be effective with respect to any use or disclosure made by the Clinic in reliance on this Authorization prior to the Date of the Clinic's receipt of my revocation.

This patient may request to receive a copy of the signed Authorization.

This Authorization will expire on the following date or event: _____

I certify that I am the Patient listed above or a person authorized to permit release of records on Patient's behalf. I hereby release The Huxford Clinic from any liability arising in connection with the use or disclosure of my protected health information pursuant to this Authorization.

Patient/Legal Representative: _____

Date: _____

Basis of authority to sign for the patient: _____