St. Dominic's

Health Information
Management Department
PH: 601.200.6830
FAX: 601.200.6826

PATIENT INFORMATION:

Name: _____ Social Security #: _____
Address: _____ Date of Birth: _____
_____ Telephone: _____

RELEASE INFORMATION:

Name of Agency Releasing Information FROM: _____
_____

Name of Agency Whom Information Will Be Released TO: _____
Address: _____
Phone: _____ Fax: _____

PURPOSE OF RELEASE:

☐ Personal ☐ Legal/Attorney ☐ Insurance ☐ Disability ☐ Continuation of Care
☐ Worker's Compensation ☐ Other: _____

INFORMATION TO BE RELEASED: The foregoing is scheduled to limitations indicated below.

Service Dates: From: _____/_____/_____ To: _____/_____/_____ Information needed by (optional): _____

Format of Release: ☐ Paper ☐ CD ☐ E-Mail E-Mail Address: _____

☐ Discharge Summary ☐ History & Physical ☐ Laboratory Reports ☐ Radiology Reports
☐ Operative Reports ☐ Consultation Reports ☐ ER Reports ☐ Radiology Images
☐ Entire Medical Record ☐ Pathology Reports ☐ HIM Abstract ☐ Therapy Notes
☐ Other:_____

☐ Confined to records regarding admission/treatment for the following medical condition or injury:
_____ Approximate Date: _____

☐ Confined to the following information: _____

☐ No limitations placed on dates, history of illness, or diagnostic and therapeutic information, including the treatment for psychological or psychiatric impairment, drug abuse and/or alcoholism, or Acquired Immunodeficiency Syndrome or test for or infection with human Immunodeficiency virus.
Patient must sign here for Authentication of this response: _____

Expiration Date of this authorization: _____

PATIENT'S RIGHTS:

The undersigned hereby authorizes and requests the above identified agency to release information regarding my medical records for the purpose of review and examination and further authorize and request that agency 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 St. Dominic's will not condition my treatment on giving 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: St. Dominic's, Privacy Officer, 969 Lakeland Drive, Jackson, MS 39216-4699.

Patient Signature: _____ Date: _____

If signed by personal representative, state relationship and authority to do so.
Representative Signature: _____ Date: _____
Authority to sign for patient: _____ Relationship to patient: _____

Request Processed by: _____ Date: _____ Time: _____
☐ Mailed ☐ Faxed ☐ E-Mailed ☐ Picked Up

Records picked up by: _____ Date: _____

CONSENT FOR RELEASE OF INFORMATION

Pages _____

MR # _____

Bottom edge of patient label here

FIN # _____