AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient / Previous Names | Birthday / Social Security / Phone Number

Street Address | City, State, Zip

I hereby authorize the release of protected health information:

To / From

MISSISSIPPI STATE UNIVERSITY™
LONGEST STUDENT HEALTH CENTER

P.O. Box 6338 Mississippi State, MS 39762
Phone: (662) 325-2431 Fax: (662) 325-8888

To / From

Name

Street

City, State, Zip

Phone Fax

SPECIFIC INFORMATION TO BE RELEASED:

____ Medical History, Examination, Reports ____ Immunization ____ X-ray Reports
____ Allergy Records ____ Laboratory Reports ____ Entire Record
____ Other (Specify): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

____ Further Medical Care ____ Legal Investigation or Action ____ Personal
____ Insurance Eligibility / Benefits ____ Changing Physicians
____ Other (Specify): _____

I understand that if the person(s) and / or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the privacy office.

Right to Receive Copy of This Authorization – I understand that if I agree to sign this authorization form, which I am not required to do, I must be provided with a signed copy of this authorization form.

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this authorization form and that the person(s) and / or organization(s) listed above who I am authorizing to use and / or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization form.

Right to Withdraw This Authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the privacy officer. I am aware that my withdrawal with not be effective as to uses and / or disclosures of my health information that the person(s) and / or organization(s) listed above have already made a reference to this authorization.

EXIPRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT / LEGAL REP: _____ **DATE:** _____

(If signed by other than the patent, state relationship and authority to do so.)

WITNESS: _____ **DATE:** _____

____ Collins ____ Crowley ____ Dodson ____ Fitts ____ Lockhart
____ Looney ____ Mabry ____ Neal ____ Pearson ____ Story

For Student Health Services Only

Information to be _____ Mailed _____ Picked Up _____ Faxed _____ Other _____ Date Needed: _____
Information sent by _____ Date: _____
Employee Name / Signature