Mississippi Sports Medicine & Orthopaedic Center, PLLC
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Mississippi Sports Medicine
And Orthopaedic Center

AUTHORITY FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Patient # _____

Date of Birth: _____ Social Security: _____

Phone #: _____ Fax #: _____

I hereby authorize _____ to use or disclose the following protected health information (PRI) of the person listed above to the following:

☐ Please fax records to person / # listed below

☐ Please mail records to patient's address below

Name: _____ Fax #: _____

Address: _____

INFORMATION TO BE DISCLOSED / RELEASED:

☐ Complete Medical Record ☐ Complete Physical Therapy Record ☐ Complete Billing Record

☐ Operative Report(s) ☐ Radiology Report(s) ☐ Radiology Films

☐ Records only from the following dates: _____ to _____

☐ Records only from the following physician(s): _____

☐ Other: _____

REASON FOR RELEASE OF INFORMATION:

☐ Insurance ☐ Continuing Care ☐ Legal ☐ 2nd Opinion ☐ Other: _____

I understand that I may revoke this consent at any time except to the extent that the action has been taken thereon. I further understand that this consent will expire six (6) months from the date of signature and cannot be renewed without my written consent. I understand that signing this authorization is voluntary and that treatment, payment, enrollment or eligibility of benefits will not be conditioned upon this authorization.

_____ _____

Signature of Patient or Patient's Legal Representative Date

Note to program receiving this information: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR, Part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.