MISSISSIPPI STATE DEPARTMENT OF HEALTH

MISSISSIPPI SEALS HIPAA AUTHORIZATION

Student Name: _____ **Parent/Guardian Name:** _____

Student Date of Birth:_____ **Sex**: Male/Female Grade: _____

Special health care needs: Yes/No **Insurance** (Circle one): Medicaid/ SCHIP/ Neither

Race: ___White __Black/African American ___Asian ___American Indian/Alaska Native ___Native Hawaiian/Pacific Islander _Other

Ethnicity: __Hispanic/Latino___Not Hispanic/Latino

AUTHORIZATION SECTION:

I, _____**,** *(Patient name – first, middle, last, maiden)* hereby voluntarily authorize_____to disclose my protected health information ("PHI") to the Mississippi State Department of Health ("MSDH") in accordance with the following:

A. Effective time period. This Authorization is valid for five (5) years, from the effective date of signature, or until revocation, death of patients, or the patient reaches the age of majority, whichever occurs first.

B. I understand that I am under no obligation to sign this Authorization. I understand that I may cancel this Authorization at any time by signing the Deny Permission Section of this form and returning it to the address below. I understand that such a cancellation does not apply to the extent that persons authorized to disclose my information have already acted in reliance on this Authorization.

C. I understand that my ability to obtain treatment, payment, enrollment, or eligibility for care will not depend on whether I sign this Authorization, except if: (1) the information is necessary to determine my enrollment or eligibility and it is not for the disclosure of psychotherapy notes, (2) such care is research related, or (3) such care is provided solely for the purpose of creating PHI for disclosure to a third party.

D. I understand that information disclosed pursuant to this Authorization, except for information pertaining to alcohol and drug abuse as defined by 42 C.F.R. Part 2, may be re-disclosed by the recipient to additional parties and may no longer be protected.

By signing below, I understand that I am giving my authorization to the dental provider and the Mississippi State Department of Health (MSDH), to use and/or disclose my child's/ward's protected health information and/or dental health assessment, for the purposes of: follow up assessments to check my child's/ward's progress and dental health; data collection, reports, documentation of oral health trends in Mississippi, or other public health activities; and/or Medicaid and grant billing. My child's name will not be disclosed in final reports or any public- facing materials, but his or her dental health information may be included in MSDH's assessment of the dental health status of Mississippi Seals program participants and/or as part of other public health activities mandated or permitted by law.

HIPAA Privacy Officer Mississippi State Department of Health
715 Pear Orchard Road, Plaza 1, Ste. 104
Ridgeland, Mississippi 39157

Si necesitaesta información en español, por favor llame 1-866-458-4948

This authorization is valid the date that it is signed by the child's parent.

_____ _____
Parent/Guardian Date

DENY PERMISSION:
I, _____,
(Patient's name – first, middle, last, maiden)
hereby voluntarily deny this Authorization for the Sharing of Protected Health Information.

Signature: By signing below, I hereby swear and affirm that the above statement is true and correct to the best of my knowledge.

_____ _____
*(Signature**)* *(Date signed – mm/dd/yyyy)*

***If not signed by the Patient, please indicate your relationship to the Patient and attach any required documentation confirming your authority to act for the Patient:*

_____