MISSISSIPPI STATE DEPARTMENT OF HEALTH

Authorization for the Use/Disclosure of Protected Health Information

Return Forms To:
Mississippi State Department of Health
Attn: OHIT Epic
570 East Woodrow Wilson Drive
P.O. Box 1700
Jackson, MS 39215-1700
Toll-free: 1-866-458-4948 | Fax: 601-576-7110

Si necesita esta información en español, consulte a su proveedor de MSDH o llame 1-866-458-4948 o comuníquese con su oficina local de MSDH. Información de contacto de las oficinas esta localizado en el sitio web de MSDH http://www.msdh.ms.gov.

Authorization Section:

I, _____
(Patient's Name – first, middle, last, maiden)
hereby voluntarily authorize the Mississippi State Department of Health (MSDH) to disclose my protected health information (PHI) in accordance with the following: *(please complete all sections)*:

A. Information to be disclosed:
Only the period of events from: _____ to _____

Only Information Related to (*please check off all that applies*):

- ☐ **Breast and Cervical Cancer Program**
- ☐ **Child Health**
- ☐ **For CMP Use Only** _____
- ☐ **Complete Medical Record**
- ☐ **Consultation Reports*** _____
- ☐ **Diabetes**
- ☐ **Early Intervention**
- ☐ **Early and Periodic Screening (EPSDT)**
- ☐ **Comprehensive Reproductive Health (Family Planning)****
- ☐ **Financial Records**
- ☐ **Genetics**
- ☐ **HIV/AIDS ****
- ☐ **Hospitalization**
- ☐ **Hypertension**
- ☐ **Job Related*** (specify)** _____
- ☐ **Laboratory Test *** _____
- ☐ **Maternity (Prenatal)**
- ☐ **Medical History *** _____
- ☐ **Medication Records**
- ☐ **Progress Notes*** _____
- ☐ **STD (other than HIV/AIDS) ****
- ☐ **Other (specify)*** _____

☐ Psychotherapy notes ONLY. *Requests for psychotherapy notes cannot be combined with any other Authorization; if you wish to authorize the disclosure of psychotherapy notes in addition to other information, please fill out a separate Authorization form for the additional information.*

Required: By authorizing MSDH to disclose your PHI, are you also giving MSDH permission to disclose your information regarding alcohol and substance use, genetic test results, HIV/AIDS, mental health (*excluding psychotherapy notes*), and sexually transmitted diseases (STDs)? ☐ Yes ☐ No

B. For the purpose of: ☐ Further medical care ☐ Personal Use ☐ Attorney ☐ Insurance ☐ School ☐ Disability ☐ Research ☐ Other: (*specify*)_____

C. Release Information to the following person/organization: *(a separate authorization form must be filled out for each person/organization)*

_____ _____
(Name of person/organization) *(If organization - name of person to receive mail)*

_____ _____
(Mailing address) *(City)* *(State)* *(Zip)*

_____ _____
(Telephone number) *(Fax number)*

_____
(E-mail address)

D. **Charges.** I understand the entity requesting access to my records may be charged a reasonable fee of $0.50 per page for copies (single-sided), a $10.00 base rate for clerical assistance, and $14.00 flat rate for Office of Disability Determination Services. If the cost of copies is expected to be substantial (greater than $25.00), MSDH should provide to me an estimate of the cost before making the copies.

E. **Effective time period.** This Authorization is valid for six months (6) months from the effective date of signature, or until revocation, death of the patient, or the patient reaches the age of majority, whichever occurs first, unless one of the following boxes is checked:

☐ This Authorization is valid for this one (1) time disclosure.
☐ This Authorization is valid for release to my attorney throughout the course of representation at his/her request.
☐ This Authorization is valid until the following expiration date: _____

F. I understand that I am under no obligation to sign this Authorization. I understand that I may revoke this Authorization at any time by signing the Revocation Section of this form and returning it to the above address. I understand that any such revocation does not apply to the extent that persons authorized to disclose my information have already acted in reliance on this Authorization.

G. 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.

H. I understand that information disclosed pursuant to this Authorization, except for 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.

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

_____ _____
(Patient Name) *(Date of birth – mm/dd/yyyy)*

_____ _____
(Social Security Number – xxx/xx/xxxx) *(Patient Identification Number)*

_____ _____
(Mailing address) *(City)* *(State)* *(Zip)*

_____ _____
(Telephone number) *(E-mail address)*

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

_____
(Printed Name of Signer)

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: _____

* Identify Program by Name
** Authorization to release Family Planning, STD, and HIV/AIDS records can only be obtained from the patient named on the record.
*** Medical information pertaining to treatment or a condition that is related to absence from work, return to work, and/or any specific restrictions such as but not limited to typing, physical locomotion, driving, lifting, standing, or sitting.

Revocation Section:

I, _____
(Patient's Name – first, middle, last, maiden)

hereby voluntarily revoke this Authorization for the Disclosure 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:*** _____