# AUTHORIZATION FOR RELEASE OF INFORMATION

**Patient Information:**

_____

PRINT Full Name of Patient DOB SS#

**Information to be released from:**

_____

Name of Tunica County Medical Clinic

_____

Address

_____

City, State, Zip Phone Number

**I request and authorize the Tunica County Medical Clinic named above to release health care information of the patient named above to:**

_____

Name of Designated Recipient

_____

Address

_____

City, State, Zip Phone Number

**Information to be released**

Medical records for the following date(s):_____ All Medical records

Billing records for the following date(s):_____ All Billing records

Specific Information (Please specify): _____

**Purpose for which disclosure is being made: (Please check one of the following)**

Attorney Insurance Doctor Personal

**Patient Authorization:**

I understand that my express consent is required to release any health care information relating to testing/ diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/ mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

**My Rights**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing at any time at the clinic address provided above. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

**Expiration**

This authorization will expire (complete one):

On _____/_____/_____

On occurrence of the following event (which must be related to the individual or to the purpose of the use and/or disclosure being authorized:

_____

**Reasonable Fee**

State law provides that a health care provider may charge a reasonable fee for copies of the requested information.

_____

Signature of Patient or Patient's Authorized Representative Date Signed

**You are entitled to a copy of this authorization after you sign it**