ST. DOMINIC MEDICAL ASSOCIATES
MEDICAL RELEASE FORM

PATIENT IDENTIFICATION:

Patient Name:________________________________ Patient Date of Birth: ______________________

Patient Address: ____

ENTITY RELEASING RECORDS:

Entity Name:________________________________

Address:________________________________

Telephone: ________________________________

Fax: ________________________________

ST. DOMINIC MEDICAL ASSOCIATES
(Clinic stamp: include address, phone, fax)

ENTITY RECEIVING RECORDS:

Entity Name:________________________________

Address:________________________________

Telephone: ________________________________

Fax: ________________________________

ST. DOMINIC MEDICAL ASSOCIATES
(Clinic stamp: include address, phone, fax)

INFORMATION TO BE RELEASED:

I am requesting the private health information for treatment dates:_________ through ______________.

Information requested
○ Operative Report ○ Patient Paperwork/Questionnaires ○ Lab
○ Discharge Summary ○ Consult Reports from other Physicians ○ Physician Orders
○ X-Ray/Imaging ○ Entire Record/Chart ○ Itemized Statement
○ Other:____

I understand that this information is to be used for the purpose of:
○ Medical Treatment ○ Insurance ○ Personal ○ Legal ○ On Patient's Request
○ Other:____

I understand that the documents authorized to be released by me include, but are not limited to, family histories, reports of clinical findings and diagnosis, laboratory test results, X-rays, reports of examination and/or evaluation, and any hospital admission or discharge records.

I understand that St. Dominic Medical Associates may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I further understand that this consent will expire **SIX MONTHS FROM DATE BELOW** and cannot be renewed without my written consent.

I understand that I may revoke this authorization in writing at any time, except to the extent of this authorization, by submitting a request to St. Dominic Medical Associates, Privacy Officer, 971 Lakeland Drive, Suite 250, Jackson, MS 39216-4699.

__________ (Initial) I understand, and here by consent that the released information may contain, but is not limited to, information concerning alcohol and drug abuse, psychiatric illness, HIV status and genetic history.

Signature of Patient: ________________________________ **Date:**________________

If signed by Representative/Guardian:
Signature of Representative/Guardian:________________________________ Date:________________

Authority to sign for Patient:________________________________ Relationship:________________

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