THE CHILDREN'S CLINIC, PLLC
P. O. Box 321434
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Authorization for Release of Health Information

PATIENT NAME _____DOB_____
ADDRESS_____
MAIN PHONE_____ALT. PHONE_____

I hereby authorize the release the following records:
_____ ALL MEDICAL RECORDS
_____ Include Mental Health/Substance Abuse Records
_____ OTHER (DESCRIBE BELOW)
_____

From: _____
(name of physician or clinic)

_____
(mailing address)

_____ _____ _____
(city) (state) (zip code)
FAX #_____

To: The Children's Clinic, PLLC
P. O. Box 321434
Flowood, MS 39232
601-936-5370 (fax)

I understand that:

- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here:_____. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given. A photocopy is as valid as the original.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient Only:_____Date:_____/_____/_____

If you are NOT the patient but are signing on behalf of the patient, please complete below:

I,_____, am the:
(print your name)

_____Parent with Parental Rights
_____Court Appointed Guardian (Must provide legal documentation)

Representative's Signature: _____ Date: _____
Relationship to Patient:_____