the children's clinic, pllc
special care for special people

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P. O. Box 321434 ● 2946 Layfair Drive ● PHONE- 601.420.8233 ● FAX- 601.936.5370

Authorization for Release of Health Information

PATIENT NAME _____**DOB**_____
ADDRESS_____
MAIN PHONE_____**ALT. PHONE**_____

I hereby authorize the release of the following records:

_____ Immunization Records Only
_____ Labs Only
_____ Include Mental Health/Substance Abuse Records
_____ Other: _____
_____ **COMPLETE MEDICAL RECORDS** (Including Mental Health/HIV/AIDS/STD/Drug & Alcohol/Psychotherapy Records)
Records to exclude from this request—please check the appropriate areas not included in your request
□ Mental Health Records-including depression
□ Drug and/or Alcohol use/abuse
□ Other: _____

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 in writing 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 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 if age 18 or older:_____Date:_____/_____/_____

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

I,_____, am the _____Parent with Parental Rights or _____Court Appointed Guardian (Must provide legal documentation)

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