# AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization for release of protected health information is provided by The Diabetes and Endocrine Center of Mississippi ("DECM"). For information about how your medical information may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer of DECM. The Notice is also posted at the DECM clinic and on the DECM website.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED .**
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION.**
- **WE WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

*THIS AUTHORIZATION IS VOLUNTARY*

**TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE**

I, (Print Patient's Name)____________________________________, Date of Birth ____________________
do hereby authorize DECM to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that information released under this authorization may be redisclosed by the recipient of the information and may no longer be protected by state and federal law.

**ATTENTION: PATIENT OR PATIENT REPRESENTATIVE PLEASE INITIAL AND COMPLETE ANY OF THE APPLICABLE OPTIONS BELOW**

________ **A ALL MEDICAL RECORDS:**

I authorize DECM to release my complete medical record (this may contain treatment notes regarding radiology, pathology ***including HIV test results and genetic testing information***, immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2***, and other common medical record documentation made by the physician, nurse or other ancillary personnel) for the entire time I was treated by DECM to the following family members or friends who contact DECM for purposes of providing them with information related to my treatment and/or payment obligations:

Name: ____________________________________ Relationship:________________________________

Name: ____________________________________ Relationship:________________________________

Name: ____________________________________ Relationship:________________________________

__________ **B MEDICAL RECORDS TO MY EMPLOYER**

I authorize DECM to release the following types of records: (description of records to be released) ________
____________________________________________________________________
________________________________________, for information collected/services provided during the time period of:____________________________________________________
________. I authorize DECM to release this information to my **employer** for the purposes of processing **FMLA forms, return to work or any other paperwork or any other information** that needs to be reported to my employer.

Employer's Name:________________________________________
Employer's Address:______________________________________
Employer's Telephone:____________________________________
Employer's Fax:_________________________________________

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| ATTENTION: PLEASE READ AND SIGN |
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I understand that DECM may contact me for purposes related to my treatment such as to remind me of appointments, leave messages that the physicians or nurse need to speak with me, to discuss financial/billing businesses, or to indicate other necessary contacts.

I understand that I may withdraw my authorization in writing to the Privacy Officer of DECM at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire ***five (5) years from this date.*** I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

________________________________________ ______________________

**Signature of patient or patient's representative** **Date**
(Form MUST be completed before signing.)

**Printed name of patient's representative***___________________________________________________
**Description of the Representative's authority to act for the patient**__________________________________
**Relationship to the patient:**______________________________________________________________

**DECM may request proof of legal representation prior to accepting this HIPAA Authorization on behalf of a patient.*