Authorization for the Use/Disclosure of Protected Health Information

Mississippi State Department of Health, Privacy Officer
570 East Woodrow Wilson Drive
P.O. Box 1700
Jackson, MS 39215-1700
Toll-free: 1-866-458-4948 | Phone: 601-576-7874

Si necesita esta información en español, consulte a su proveedor de MSDH o llame 1-866-458-4948 o comuníquese con su oficina local de MSDH. Información de contacto de las oficinas esta localizado en el sitio web de MSDH http://www.msdh.ms.gov.

Authorization Section:

I,_____,
(Patient name – first, middle, last, maiden)
hereby voluntarily authorize the Mississippi State Department of Health ("MSDH") to disclose my protected health information ("PHI") in accordance with the following: *(please complete all sections)*:

A. Information to be disclosed:
Only the period of events from: _____ to _____
Only Information Related to (*please check off all that applies*):

- ☐ **Breast and Cervical Cancer Program**
- ☐ **Child Health**
- ☐ **For CMP Use Only _____**
- ☐ **Complete Medical Record**
- ☐ **Consultation Reports _____**
- ☐ **Early and Periodic Screening (EPSDT)**
- ☐ **Diabetes**
- ☐ **Early Intervention**
- ☐ **Comprehensive Reproductive Health (Family Planning)**
- ☐ **Financial Records**
- ☐ **Genetics**
- ☐ **HIV/AIDS**
- ☐ **Hospitalization**
- ☐ **Hypertension**
- ☐ **Job Related*** (specify) _____**
- ☐ **Laboratory Test * _____**
- ☐ **Maternity (Prenatal)**
- ☐ **Medical History * _____**
- ☐ **Medication Records**
- ☐ **Progress Notes* _____**
- ☐ **Screening, Diagnosis and Treatment Program**
- ☐ **STD (other than HIV/AIDS)**
- ☐ **Other (specify) _____**

☐ Psychotherapy notes ONLY. *Requests for psychotherapy notes cannot be combined with any other Authorization; if you wish to authorize the disclosure of psychotherapy notes in addition to other information, please fill out a separate Authorization form for the additional information.*

Required: By authorizing MSDH to disclose your PHI, are you also giving MSDH permission to disclose your information regarding alcohol and drug abuse, genetic test results, HIV/AIDS, mental health (*excluding psychotherapy notes*), and sextually transmitted diseases (STDs)? ☐ Yes ☐ No

B. For the purpose of: ☐ Further medical care ☐ Personal Use ☐ Attorney ☐ Insurance ☐ School ☐ Disability ☐ Research ☐ Other: (*specify*)_____

C. Release Information to the following person/organization: *(a separate authorization form must be filled out for each person/organization)*

_____ _____
(Name of person/organization) *(If organization - name of person to receive mail)*

_____ _____
(Mailing address) *(City)* *(State)* *(Zip)*

_____ _____
(Telephone number) *(Fax number)*

_____
(Email address)

D. Charges. I understand the entity requesting access to my records may be charged a reasonable fee of $0.25 per page for copies (single-sided) and a $10.00 base rate for clerical staff time. If the cost of copies is expected to be substantial (greater than $25.00), MSDH should provide to me an estimate of the cost before making the copies.

E. Effective time period. This Authorization is valid for six months (6) months from the effective date of signature, or until revocation, death of the patient, or the patient reaches the age of majority, whichever occurs first, unless one of the following boxes is checked:

☐ This Authorization is valid for this one (1) time disclosure.
☐ This Authorization is valid for release to my attorney throughout the course of representation at his/her
☐ request. This Authorization is valid until the following expiration date: _____

F. I understand that I am under no obligation to sign this Authorization. I understand that I may revoke this Authorization at any time by signing the Revocation Section of this form and returning it to the above address. I understand that any such revocation does not apply to the extent that persons authorized to disclose my information have already acted in reliance on this Authorization.

G. I understand that my ability to obtain treatment, payment, enrollment, or eligibility for care will not depend on whether I sign this Authorization, except if: (1) the information is necessary to determine my enrollment or eligibility and it is not for the disclosure of psychotherapy notes, (2) such care is research related, or (3) such care is provided solely for the purpose of creating PHI for disclosure to a third party.

H. I understand that information disclosed pursuant to this Authorization, except for alcohol and drug abuse as defined by 42 C.F.R. Part 2, may be re-disclosed by the recipient to additional parties and may no longer be protected.

Signature: By signing below, I hereby swear and affirm that the above statements are true and correct to the best of my knowledge.

_____ _____
Patient Name *(Date of birth – mm/dd/yyyy)*

_____ _____
(Social Security Number – xxx/xx/xxxx) *(Patient Identification Number)*

_____
(Mailing address)

_____ _____
(Telephone number) *(E-mail address)*

_____ _____
(Signature) *(Date signed – mm/dd/yyyy)*

If not signed by the patient, please indicate your relationship to the Patient and attach any required documentation confirming your authority to act for the Patient: _____

* Identify Program by Name
** Authorization to release Family Planning records can only be obtained from the patient named on the record.
*** Medical information pertaining to treatment or a condition that is related to absence from work, return to work, and/or any specific restrictions such as but not limited to typing, physical locomotion, driving, lifting, standing or sitting

Revocation Section:

I, _____
(Patient's name – first, middle, last, maiden)
hereby voluntarily revoke this Authorization for the Disclosure of Protected Health Information.

Signature: By signing below, I hereby swear and affirm that the above statement is true and correct to the best of my knowledge.

_____ _____
*(Signature**)* *(Date signed – mm/dd/yyyy)*

***If not signed by the Patient, please indicate your relationship to the Patient and attach any required documentation confirming your authority to act for the Patient:* _____

AUTHORIZATION FOR THE USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION
Form #99

PURPOSE
To provide a means for MSDH patients or employees to authorize the release of their health information to a third party designated by the individual.

INSTRUCTIONS

The patient or individual must complete and sign Form #99 to authorize the release of information to a third party (other than health care providers).

Step 1: On page 1, the patient will need to enter their first, middle, last, and maiden name, if applicable.

Step 2: On page 1, Section A (Information to be disclosed), the patient must indicate the dates of service and specify the records being requested by checking the boxes listed.

Step 3: On page 1, Section B (For the purpose of), the patient must indicate the purpose of the disclosure/release.

Step 4: On page 1, Section C (Release Information to the following person/organization), the patient must indicate who and where MSDH is to release their records.

Step 5: On page 2, Section E (Effective time period), if the patient wishes to establish a different effective time period than described, that must be noted in this section.

Step 6: The patient will then need to sign the form under the Signature section on page 2. Please make sure this section is completely filled out and the patient's identity is verified before any records are released.

> **Note:** Please note if this form is not signed by the patient, the person signing the form must indicate their relationship to the patient and attach any required documentation confirming their authority to act for the patient (e.g. power of attorney, divorce decree/custody agreement, etc.)

Revocation Section: This section should only be completed if the patient wishes to revoke an authorization that was previously approved.

OFFICE MECHANICS AND FILING

Receipt of a Release of Information by another entity – Prepare original and one copy.

Keep copy in patient or individual's file and send original to requesting entity for patient's signature. When form has been returned with signature, keep original in patient's medical record and send the copy along with requested information. Note on the form the date that information was mailed.

RETENTION PERIOD

Scan into patient's electronic medical record. Retain according to agency policy for that type patient retention schedule.

MSDH FEES FOR PROVIDING PATIENT INFORMATION

Agency policy allows a reasonable fee to be charged for copies of patient information provided to designated third parties.

Exemptions from the Fee Requirement

- Maternity records
- WIC records given to a WIC client transferring to another provider
- Initial lab test results
- Immunization records
- Records transferred to another health care provider pursuant to patient care
- Records transferred to the Department of Education, Human Services, or any other social service agency relative to patient care, referral or consultation
- Records provided to an insurance carrier as needed for reimbursement
- Medicaid beneficiaries may not be charged for the cost of copying medical records