Premier Choice Healthcare

1832 Hospital Drive Jackson, MS 39204
Office: (601) 371-8883
Fax: (844) 318-4882

Authorization for Release of Health Information

PATIENT NAME ____

DOB ____

ADDRESS ____

MAIN PHONE ____

ALT. PHONE ____

I hereby authorize Premier Choice Healthcare to release the following records:

_____ Immunization Records Only
_____ Labs Only
_____ Include Mental Health/Substance Abuse Records
_____ Other: ____

_____ **COMPLETE MEDICAL RECORDS**
(Including Mental Health/HIV/AIDS/STD/Drugs & 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: ____

TO: ____
(name of physician or clinic)

____
(mailing address)

__________________________ __________ __________
(city) (state) (zip code)

FAX #_______________________________

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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) for the above name patient.

Representative's Signature: ____________________________________ Date: __________________

Relationship to Patient: ____