Mississippi Children's HEART CLINIC

RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____ / ____ / _____ Medical Record #: _____

INFORMATION TO BE RELEASED

Please release the following information (check all that apply):

- ☐ Clinical Records / Office Notes
- ☐ Consultations
- ☐ Diagnostic Test Results
- ☐ Laboratory Reports
- ☐ Imaging / Radiology Reports
- ☐ Operative Reports
- ☐ Discharge Summary
- ☐ Medication List
- ☐ Immunization Records
- ☐ Billing / Payment Records
- ☐ Other (please specify): _____

INFORMATION TO BE RELEASED FROM

Provider / Facility / Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED TO

Provider / Facility / Organization: Mississippi Children's Heart Clinic

Address: 1190 N State Street, Suite 200, Jackson, MS 39202

City: Jackson State: MS Zip: 39202

Phone: (601) 965-6100 Fax: (601) 965-5300

PURPOSE OF DISCLOSURE

☐ Continuation of Care ☐ Second Opinion ☐ Insurance ☐ Legal ☐ Other: _____

AUTHORIZATION

I understand that I may revoke this authorization at any time by writing to Mississippi Children's Heart Clinic, except to the extent that action has already been taken in reliance on this authorization. I understand that the information released may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

This authorization will expire one (1) year from the date signed below unless otherwise specified here: _____

Parent / Legal Guardian Signature: _____ Date: ____ / ____ / _____

Parent / Legal Guardian Name (Print): _____

Relationship to Patient: _____