McComb Children's Clinic
309 Llewellyn Ave.,McComb, MS 39648 Phone:
601-684-7623 Fax: 833-906-2569

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AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Receive Records FROM)

I hereby authorize the USE & DISCLOSURE of:
___medical records dated _____ OR ___any and all medical records
for the purpose of _____ OR ___continuity of care
(including but not limited to records of any substance abuse, psychiatric/mental health information or HIV/AIDS information) of:

PATIENT'S NAME:_____ CHART # _____
(PLEASE PRINT)
ADDRESS:_____ PHONE:_____
_____ DATE OF BIRTH:_____

Organization Authorized to Release Information:

_____

_____

_____

Fax _____

Phone _____

Person/Organization Authorized to Receive Information:

McCOMB CHILDREN'S CLINIC
309 Llewellyn Ave.
McCOMB, MS 39648

PHONE: 601-684-7623
FAX: 833-906-2569

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed to a third party and no longer be protected by these regulations.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment or healthcare operations. I may inspect or copy any information used/disclosed under this authorization.
This authorization and request if fully understood and is made voluntarily on my part. I release the above-named facility of any legal liability that may arise from the release of the information requested.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
WITNESS SIGNATURE: _____ DATE: _____

I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. This authorization will expire automatically 60 days from the date on which it was signed. Cancellation of this authorization prior to the 60-day limit must be made in writing and sent to the McComb Children's Clinic.