Authorization/Request for Protected Health Information

MAGNOLIA REGIONAL HEALTH CENTER
–All Roads Lead To Magnolia–

Patient Name (Print): _____ **DOB:** _____ **SS#** (Last 4 digits): _____

Patient's Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Contact Number: _____

Format of the Release:
I understand that I have the right to receive my health information in the form and format of my preference to the extent my information is held in electronic form and MRHC is capable of fulfilling the request. I also understand that I may request my information to be sent via unencrypted email or to my unsecure email account. By choosing that type of format, I accept the fact that my information may be at risk of being read or accessed by someone else.

Method of Disclosure:

☐ Paper ☐ Password Protected CD ☐ Patient Portal Fax #_____

☐ Secure E-mail ☐ Unsecure E-mail* ☐ Other: _____

*By selecting unsecure email, I understand and agree that my protected health information is subject to being intercepted during transmission and read, copied, or forwarded by anyone.

Type of Request

☐ Proof of Birth ☐ SS#/Drivers License ☐ Medical Care ☐ Personal

☐ Legal ☐ Health Insurance ☐ Other Insurance ☐ Workers Comp

Protected Health Information to be Released (check below): Date(s) of Service: _____

☐ Complete Medical Record ☐ Operative Reports ☐ ER Reports ☐ Radiology Reports

☐ History & Physical(s) ☐ Consult Reports ☐ Outpatient Records ☐ Abstract

☐ Discharge Summary ☐ Lab/ Path Reports ☐ Clinic Other: _____

Designated individual to receive the records: ☐ **Self or** ☐ **Authorized Representative**

Contact Information for Recipient:
Full Name: _____
Address: _____
Phone Number: _____
Email Address:

POA ☐ Yes ☐ No ☐ On file

NOTICE TO PATIENT: You or your authorized representative may inspect and/or obtain a copy of health information to be used or disclosed as permitted under state or federal law. This authorization will expire in **90 days** from the date of my signature. I understand I have the right to revoke this authorization at any time, in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have acted in reliance upon this authorization. Furthermore, I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected. Under Federal HIPAA regulations, MRHC is generally required to allow patients access to and copies of their record within 30 days and may charge patients for the cost of copying and sending the records. Any direct access will be under direct supervision by HIM personnel or designee.

I understand that I do not have to sign this authorization/request and that my refusal to sign will not affect my ability to obtain treatment from MRHC.

I authorize/request Magnolia Regional Health Center and any MRHC owned clinics to release the health information as described above.

_____ _____

Signature of Patient or Qualified Personal Representative **Date/Time:**

If signed by a qualified Personal Representative, the following must be completed:

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient: _____

(Example: Patient, Guardian, Executor of Estate)

MRHC USE ONLY Account # _____ Unit # _____

Identification Verified by Person Receiving Request ☐ Signature ☐ Picture ID ☐ Verbal Consent _____ Date _____

Copy / Access Granted ☐ Date _____

Copy / Access Delayed ☐ Date Notice Given _____

Access Denied ☐ Date _____

Reason for Denial ☐ Health Care Professional Determination ☐ Research in process ☐ Administrative Decision ☐ Other _____

Return completed form to the HIM Department or fax to (662) 293-4241 or call (662) 293-1255 or mail to MRHC, Attn: HIM Department, 611 Alcorn Drive, Corinth, MS 38834