Midsouth Medical, Inc.
HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

1. Authorization
I authorize to use and disclose the protected health information described below to Midsouth Medical, Inc. (individual seeking the information).

2. Effective Period
This authorization for release of information covers the period of healthcare from:

- ☐ _____ to _____ **OR**
- ☑ all past, present, and future periods.

**3. Extent of Authorization*
This authorization for release of information extends to:

- ☑ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). **OR**
- ☐ I authorize the release of my complete health record except for the following information
  - Mental health records
  - Communicable diseases (including HIV and AIDS)
  - Alcohol/drug abuse treatment
  - Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until - indefinitely - (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient ID & DOB: _____

Patient or Patient's Representative: _____

Relationship to Patient (if not 'Self'): _____

Reason Patient Could Not Sign: _____

Company Representative: _____

Date: _____