AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

| | / XXX-XX / | | | | | | |
|--|---------------------------|------------------------|--------------|--|--|--|--|
| Name of Patient/Previous Names | Birth Date | Social Security Number | Phone Number | | | | |
| Street Address | City, State, Zip | | | | | | |
| I hereby authorize the release of protected health | information: | | | | | | |
| To / From: | To / From: | | | | | | |
| John C Longest Student Health Center P O Box 6338 | Name: | Name: | | | | | |
| Mississippi State, MS 39762 | Address: | Address: | | | | | |
| Phone: 662 325-2431 Fax: 662 325-8888 | City,State,Z | ip: | | | | | |
| | Phone: | | Fax: | | | | |
| Please return | a copy of this release w | ith records. | | | | | |
| SPECIFIC INFORMATION TO BE RELEASED |): | | | | | | |
| Medical History, Examination, Reports | Immunizations | X- | ray Reports | | | | |
| Allergy Records | Laboratory Reports | | tire Record | | | | |
| Behavioral Health Records | | | | | | | |
| PURPOSE FOR NEED OF DISCLOSURE: (Chea | ak applicable catagorias) | | | | | | |
| Further Medical Care | | Action Do | sonal | | | | |
| | Legal Investigation or | ActionPer | 501141 | | | | |
| Insurance Eligibility/Benefits | Changing Physicians | | | | | | |
| Other (Specify): | | | | | | | |

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the privacy officer. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization on how to withdraw This Authorization - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the privacy officer. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _______ or for one year from the date signed. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP:

KEF: DATE:

 (If signed by other than patient, state relationship and authority to do so.)

DATE:

WITNESS:

Records requested for: Dodson Sesser Lockhart Gholson Mabry Pearson Poe McCullough McBeth-Harris Please return a copy of this release with records.

For Student Health Service Use Only

| Information to be | _Mailed | _Picked Up | Faxed _ | Other | | Date Needed: | |
|------------------------|--------------|--------------|---------|-------|-------|--------------|--|
| Information sent by: _ | | | | C | Date: | | |
| Revised 9/21/22 | Employee Nar | me/Signature | | | | | |