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:
John C Longest Student Health Center
P O Box 6338
Mississippi State, MS 39762

Phone: 662 325-2431 Fax: 662 325-8888

To / From:
Name: _____

Address: _____

City,State,Zip: _____

Phone: _____Fax: _____

Please return a copy of this release with records.

SPECIFIC INFORMATION TO BE RELEASED:

___ Medical History, Examination, Reports ___ Immunizations ___ X-ray Reports
___ Allergy Records ___ Laboratory Reports ___ Entire Record
___ Behavioral Health Records

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

___Further Medical Care ___ Legal Investigation or Action ___ Personal
___ 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. **Right 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: _____DATE: _____

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

WITNESS: _____

Records requested for: ☐ Dodson ☐ Lockhart ☐ McBeth-Harris ☐ McCullough ☐ Pearson ☐ Poe ☐ Sesser

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: _____ Date: _____

Employee Name/Signature

Revised 5/23/2025