AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize and request the use and disclosure of the following protected health information (PHL) from the medical records of the patient listed below to:

The Surgical Clinic Associates, P.A.
501 Marshall Street, Suite 500 Jackson, MS 39202
Telephone 601-948-1411 **Facsimile** 601-352-0848

G. Edward Copeland, III, M.D.
Alexander J. Haick, Jr., M.D.
Nathan D. Maples, M.D.
Jason G. Murphy, M.D.
Anthony B. Petro, M.D.
Andrew C. Mallette, M.D.
Gina E. Heath, M.D.
Erin R. Cummins, M.D.

Patient Name: _____

Patient Date of Birth: _____ **Patient SS#**: _____

Patient Address: _____

Patient Phone Number: _____

OFFICAL USE ONLY:

Disclose the following PHI for treatment dates _____to_____ (if no dates entered, send all)

(Please check the applicable item or items)
( ) Entire Chart
( ) Progress Notes ( ) Procedure Op Notes/ Hospital Summary ( ) Lab
( ) X-ray Report ( ) Telephone Message ( ) Pathology Report
( ) Other Specified: _____

The above information is disclosed for the following purposes:
(Please check all applicable)
( ) Medical Care ( ) Legal ( ) Insurance ( ) Personal ( ) Other: _____

I understand that medical records may include information regarding a sexually transmitted disease, AIDS, or HIV infection as well as information about behavioral or mental health services or treatment for alcohol and drug abuse.
I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by confidentiality rules. I also understand that the degree of confidentiality can be modified with a facsimile transmission and that the Practice and Physician are not responsible for records once they have been transmitted.

I choose to have my records faxed to my primary care physician, other doctors or hospitals upon request. _____ (please initial)

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and will not apply to information already released under this authorization. Unless otherwise revoked, this authorization is effective for six months from the date signed.

Signature of Patient or Legal Representative: _____Date:_____

If Legal Representative-Relationship to Patient: _____

Witnessed by: _____ Date: _____