Women's Medical Center of Meridian, P.A.

1523 22nd Avenue – Meridian, MS 39301
Phone: 601-483-0039 Fax: 601-485-7240

Daniel J. McKiever, Jr., M.D.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION TO WMC

_____ _____ _____
PATIENT NAME (please print) PATIENT SOCIAL SECURITY # PATIENT DATE OF BIRTH

I I hereby authorize the use or disclosure of my protected health information as described below.

Doctor/Organization to RELEASE Medical Records

_____
NAME OF DOCTOR FROM WHOM YOU ARE REQUESTING RECORDS

_____
ADDRESS OF DOCTOR/ORGANIZATION

_____
CITY STATE ZIP

_____
PHONE FAX

Doctor/Organization to RECEIVE Medical Records

WOMEN'S MEDICAL CENTER
NAME OF DOCTOR/ORG. TO RECEIVE YOUR RECORDS

1523 22nd Avenue
ADDRESS OF DOCTOR/ORGANIZATION

Meridian, MS 39301
CITY STATE ZIP

601-483-0039 601-485-7240
PHONE FAX

Disclose the following medical records for treatment dates _____ to _____:

_____ Entire Medical Records

_____ Other (specify): _____

_____

I acknowledge and hereby consent to such that the released information may contain alcohol and drug abuse, psychiatric or mental care/treatment, HIV, AIDS, STD test result, or genetic information.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Women's Medical Center of Meridian, P.A. I understand that the revocation will not apply to information that has already been released as a result of this authorization.

If the requested or the receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may not be disclosed.

This authorization shall expire upon this expiration date: _____. If I fail to specify an expiration date, this authorization will expire six months from the date on which it was signed and dated.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
SIGNATURE OF PATIENT OR PARENT/LEGAL REPRESENTATIVE DATE

If signed by legal representative, relationship to the patient: _____

_____ _____
SIGNATURE OF WITNESS DATE