Family Medical Clinic of North Mississippi, Inc.
3451 Goodman Road Suite 115
Southaven, MS 38672
Phone: 662-890-5555 Fax: 662-890-8899

Medical Release of Information

Patient name____

Address____

Social Security #____________________________ D.O.B.______________________
The above identified patient is requesting the following information be made available to:

Name of Person/Organization to **RECEIVE** information_________________________

Address ____

Name of Person/Organization information **REQUESTED** from____________________

Address____

Information to be released: Please check all applicable records to release
_____ **ALL RECORDS**

_____ Medical record Dates of service: From_________ to ___________

_____ Immunization record Dates of service: From_________ to ____________

_____ Mental Health record Dates of service: From_________ to ____________

_____ Other Dates of service: From_________ to ____________

Please specify____

I understand that I have the right to refuse to sign this form and that my refusal will not affect my healthcare with two exceptions: 1. If it is for disclosure of information created for research that includes treatment refusal may result in the physician declining to provide research-related treatment. 2. If it is for disclosure of information created for the sole purpose of disclosure to a third party for enrollment, benefits eligibility, payment, worker's compensation etc. refusal may effect payment for services and I may become responsible for payment.

I understand this authorization will expire in 90 days or on the following date:_________.

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Signature of Patient:__________________________________ Date:________________

Signature of Parent/Guardian__________________________ Relationship___________