INDIVIDUAL AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OTHER THAN TREATMENT OR PAYMENT

I, ____ (patient), hereby knowingly and voluntarily authorize and allow Northeast Mississippi Health Care, Inc. to disclose and share my personal health information with the following indicated and named persons:

- O Spouse: ______________________________
- O Mother: ______________________________
- O Father: ______________________________
- O Brother: ______________________________
- O Sister: ______________________________
- O Grandparent: ______________________________
- O Daughter: ______________________________
- O Son: ______________________________
- O Others: ______________________________

  Relationship ______________________________

I understand that I have the right to revoke this authorization in writing at any time, and I understand that I must deliver a written notice of cancellation to the front desk at either Byhalia Family Health/Dental Center or Mt. Pleasant Family Health Clinic. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer will be protected by the privacy regulations.

____ ______________________

Signature of the Patient/Representative Date

If the authorization is signed by a personal representative, a description of the representative's authority to act is attached (Power of Attorney, Court Order, etc.)