Northeast Mississippi Health Care, Inc.
Byhalia Family Health Center ~ Mt. Pleasant Family Health Center
Desoto Community Health Center
P O Box 698
Byhalia, MS 38611
(662)838-2163 (662)838-7945

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Affix Label Here

I request and authorize______________________________ to Release/Obtain healthcare information of the above named patient to/from:

Name: ____

Address: ____

City: ________________ State: ________________ Zip Code: ________________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates of service:

____

____

☐ All healthcare information:

____

☐ Other: ____

My authorization is given freely with the understanding

- I may refuse to sign this authorization
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing
- I will be required to pay any applicable fees for copies or postage in advance.
- NEMHC, Inc. may not condition my treatment on my provision of this authorization.
- The authorization is valid for a 1 year period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of the authorization is valid as the original.
- NEMHC, Inc. its directors, officers, employee, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I will be given a copy of this signed authorization per my request.

Patient Signature: ______________________________ Date Signed: ____________________
(or signature of person authorized to consent for minor patient)
Relationship and/or authority to act on behalf of patient ______________________________