MISSISSIPPI MUNICIPAL SERVICE COMPANY

HIPAA Medical Authorization Form

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND REPORTS

FULL NAME: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NO:** _____

I hereby authorize all health care providers, physicians, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals, and pharmacies, to release all existing medical records and information regarding the above referenced patient's medical care, treatment, physical/medical condition, and medical expenses revealed by your observation or treatment of past, present and future to the MISSISSIPPI MUNICIPAL SERVICE COMPANY or its representative, or the bearer hereof, or the bearer of any photo static or Xerox copy hereof.

I understand that this authorization includes information regarding the diagnosis and treatment of drug, alcohol, Acquired Immune Deficiency Syndrome (AIDS), and psychiatric and psychological disorders (EXCEPT *Psychotherapy Notes * as defined by the Health Insurance Portability and Accountability Act 45 CFR 164.501, psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record.* Psychotherapy notes require a separate authorization.) It also includes x-ray reports, laboratory reports, CT scan reports, MRI scans, EEG's, EKG's, sonograms, arteriograms, fetal monitor strips, discharge summaries, photographs surgery consent forms, informed consent forms regarding family planning, admission and discharge records, operation records, doctor and nurses notes, prescriptions, medical and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other document or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc). This listing is not meant to be exclusive.

I, the undersigned individual, am on notice that:

(1) Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.
(2) Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
(3) This authorization can be revoked through written notice to MS MUNICIPAL SERVICE COMPANY, or to the individual above listed entities, except to the extent that action has been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.
(4) A photocopy of this authorization shall be considered as effective and valid as the original.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, _____, to those persons or agencies listed above.

Date: _____

Patient or Patient Representative _____
(Signature)

Name of Patient's Representative _____
(Print Name)

Relationship _____

_____
Description of Representative's Authority to Act for the Patient

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.

**Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress date.*

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