Zovielles
Family Medical and Behavioral Health Care, LLC

7 Lakeland Circle
Suite 500
Jackson, MS 39216

Phone: 601-203-2906

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information will be released for the patient as indicated below, upon appropriate completion of this authorization.

Last Name First Name MI Maiden/Other Name Date of Birth

Street Address City State/Zip Phone Number

In making a request for medical information, please check one of the two options below:
☐ You are the patient, the patient's designated personal representative or the patient's guardian.
☐ You are affiliated with **Zovielles Family Medical** and so authorized to request medical information on behalf of the patient for further treatment. NOTE : Healthcare providers may request medical information from another provider for further treatment as codified at *45 CFR 164.506(b)2 and (c)2* of the HIPAA Privacy Rule.

The information to release will cover the period from _____ to _____

Purpose of release (***REQUIRED***): ☐ Continuation of Care ☐ Personal Reasons ☐ Insurance ☐ Legal
☐ Other (fill-in): _____

Release the information from:

Name: _____
Address: _____
_____
Fax: _____

Disclose the information to:

Name: **7 Lakeland Circle**
Address: **Suite 500**
Jackson, MS 39216

Phone: 601-203-2906

Requested medical information (Either check complete **OR** check only those that apply)
☐ Complete Medical Records, including any/all records received by other healthcare providers

☐ Clinic Notes	☐ EEG, EKG, Stress Test	☐ Immunizations	☐ Operation Report(s)
☐ Consultation Notes	☐ Emergency Room Record	☐ Itemized Bill(s)	☐ Pathology Reports
☐ Disability/FMLA Forms	☐ Endoscopy	☐ Laboratory Reports	☐ Radiology Reports
☐ Discharge Summary	☐ History & Physical	☐ Medications	

☐ Other (specify):_____

NOTE: While **Zovielles Family Medical** makes every effort to protect the privacy of your medical information, please note that release of your medical information to the authorized person or organization could be the subject of re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA") or other federal or state laws.

- Records related to HIV status may not be release unless the individual has signed a separate release specific to HIV related information. 5 U.S.C. §19203-D.
- Psychotherapy notes may not be release unless the individual has signed a separate release specifying that such notes may be released. 45 CFR § 164.508 (b)(3)(ii).
- Drug or alcohol records may not be release unless authorization specifies extent and nature of records to be released. 42 U.S.C 290dd-3; 42 U.S.C. 290ee-3; 42 CFR, Part 2.
- This authorization expires one year from date of signature.

X_____ Date: _____
Signature of Patient/Parent/Guardian