Authorization for the Use/Disclosure of Protected Health Information

Mississippi Division of Medicaid, Privacy Officer
Walter Sillers Building
Post Office Box 2222
Jackson, Mississippi 39225
Toll-free: (800) 421-2408 | Phone: (601) 359-6050

Si necesita esta información en español, por favor llame 1-800-421-2408

Authorization Section:

I, _____,
(Applicant/Beneficiary's name – first, middle, last, maiden)
hereby voluntarily authorize the Mississippi Division of Medicaid ("DOM") to disclose my protected health information ("PHI") in accordance with the following: *(please complete all sections)*

A. Information to be disclosed:

- ☐ All information
- ☐ Only information related to: _____
- ☐ Only the period of events from: _____ to _____
- ☐ Psychotherapy notes ONLY. *Requests for psychotherapy notes cannot be combined with any other Authorization; if you wish to authorize the disclosure of psychotherapy notes in addition to other information, please fill out a separate Authorization form for the additional information.*
- ☐ Other: *(specify)* _____

Required: By authorizing DOM to disclose your PHI, are you also giving DOM permission to disclose your information regarding alcohol and drug abuse, family planning, genetic test results, HIV/AIDS, mental health (*excluding psychotherapy notes*), and sexually transmitted diseases ("STDs")? ☐ Yes ☐ No

B. For the purpose of: ☐ Further medical care ☐ Personal use ☐ Attorney ☐ Insurance ☐ School ☐ Disability ☐ Research ☐ Other: *(specify)* _____

C. To the following person/organization: *(a separate authorization form must be filled out for each person/organization)*

_____ _____
(Name of person/organization) *(If organization - name of person to receive mail)*

_____ _____
(Mailing address) *(City)* *(State)* *(Zip)*

_____ _____
(Telephone number) *(Fax number)*

_____
(Email address)

D. Effective time period. This Authorization is valid for twelve (12) months from the effective date of signature, or until revocation, death of the Applicant/Beneficiary, or the Applicant/Beneficiary reaches the age of majority, whichever occurs first, unless one of the following boxes is checked: *(continued on next page)*

- ☐ This Authorization is valid for this one (1) time disclosure.

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☐ This Authorization is valid for release to my attorney throughout the course of representation at his/her request.
☐ This Authorization is valid until the following expiration date: _____

E. I understand that I am under no obligation to sign this Authorization. I understand that I may revoke this Authorization at any time by signing the Revocation Section of this form and returning it to the above address. I understand that any such revocation does not apply to the extent that persons authorized to disclose my information have already acted in reliance on this Authorization.

F. I understand that my ability to obtain treatment, payment, enrollment, or eligibility for care will not depend on whether I sign this Authorization, except if: (1) the information is necessary to determine my enrollment or eligibility and it is not for the disclosure of psychotherapy notes, (2) such care is research related, or (3) such care is provided solely for the purpose of creating PHI for disclosure to a third party.

G. I understand that information disclosed pursuant to this Authorization, except for alcohol and drug abuse as defined by 42 C.F.R. Part 2, may be re-disclosed by the recipient to additional parties and may no longer be protected.

Signature: By signing below, I hereby swear and affirm that the above statements are true and correct to the best of my knowledge.

_____ _____
(Applicant/Beneficiary's name) *(Date of birth – mm/dd/yyyy)*

_____ _____
(Social Security Number – xxx/xx/xxxx) *(Medicaid Identification Number)*

_____
(Mailing address)

_____ _____
(Telephone number) *(E-mail address)*

_____ _____
(Signature)* *(Date signed – mm/dd/yyyy)*

**If not signed by the Applicant/Beneficiary, please indicate your relationship to the Applicant/Beneficiary and attach any required documentation confirming your authority to act for the Applicant/Beneficiary:* _____

Revocation Section:

I, _____,
(Applicant/Beneficiary's name – first, middle, last, maiden)
hereby voluntarily revoke this Authorization for the Disclosure of Protected Health Information.

Signature: By signing below, I hereby swear and affirm that the above statement is true and correct to the best of my knowledge.

_____ _____
*(Signature**)* *(Date signed – mm/dd/yyyy)*

***If not signed by the Applicant/Beneficiary, please indicate your relationship to the Applicant/Beneficiary and attach any required documentation confirming your authority to act for the Applicant/Beneficiary:* _____

For official DOM use only:

Authorization received on:	Received by:	Revocation received on:	Received by: