MISSISSIPPI STATE DEPARTMENT OF HEALTH

Authorization for the Use/Disclosure of Protected Health Information

Return Forms To:
Mississippi State Department of Health
Attn: OHIT Epic
570 East Woodrow Wilson Drive
P.O. Box 1700
Jackson, MS 39215-1700
Toll-free: 1-866-458-4948 | Fax: 601-576-7110

Si necesita esta información en español, consulte a su proveedor de MSDH o llame 1-866-458-4948 o comuníquese con su oficina local de MSDH. Información de contacto de las oficinas esta localizado en el sitio web de MSDH http://www.msdh.ms.gov.

Authorization Section:

I,_____**,**
(Patient name – first, middle, last, maiden)
hereby voluntarily authorize the Mississippi State Department of Health ("MSDH") to disclose my protected health information ("PHI") in accordance with the following: *(please complete all sections)*:

A. Information to be disclosed:

Only the period of events from: _____to _____

Only Information Related to (*please check off all that applies*):

- ☐ **Breast and Cervical Cancer Program**
- ☐ **Child Health**
- ☐ **For CMP Use Only** _____
- ☐ **Complete Medical Record**
- ☐ **Consultation Reports** _____
- ☐ **Diabetes**
- ☐ **Early Intervention**
- ☐ **Early and Periodic Screening (EPSDT)**
- ☐ **Comprehensive Reproductive Health (Family Planning)****
- ☐ **Financial Records**
- ☐ **Genetics**
- ☐ **HIV/AIDS****
- ☐ **Hospitalization**
- ☐ **Hypertension**
- ☐ **Job Related*** (specify)** _____
- ☐ **Laboratory Test *** _____
- ☐ **Maternity (Prenatal)**
- ☐ **Medical History *** _____
- ☐ **Medication Records**
- ☐ **Progress Notes*** _____
- ☐ **STD (other than HIV/AIDS)****
- ☐ **Other (specify)** _____

☐ Information potentially related to **reproductive health ca**re. If this box is checked, you are required to review, complete in full, and sign the Attestation form. The attestation form and its instructions are the last pages of this document.

☐ 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.*

Required: By authorizing MSDH to disclose your PHI, are you also giving MSDH permission to disclose your information regarding alcohol and substance use, genetic test results, HIV/AIDS, mental health (*excluding psychotherapy notes*), and sextually transmitted diseases (STDs)? ☐ Yes ☐ No

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

C. Release Information 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. Charges. I understand the entity requesting access to my records may be charged a reasonable fee of $0.25 per page for copies (single-sided) and a $10.00 base rate for clerical staff time. If the cost of copies is expected to be substantial (greater than $25.00), MSDH should provide to me an estimate of the cost before making the copies.

E. Effective time period. This Authorization is valid for six months (6) months from the effective date of signature, or until revocation, death of the patient, or the patient reaches the age of majority, whichever occurs first, unless one of the following boxes is checked:

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

F. 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.

G. 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.

H. 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.

Patient Name *(Date of birth – mm/dd/yyyy)*

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

(Mailing address)

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

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

(Printed Name of Signer)

If not signed by the patient, please indicate your relationship to the Patient and attach any required documentation confirming your authority to act for the Patient: _____

* Identify Program by Name
** Authorization to release Family Planning, STD, and HIV/AIDS records can only be obtained from the patient named on the record.
*** Medical information pertaining to treatment or a condition that is related to absence from work, return to work, and/or any specific restrictions such as but not limited to typing, physical locomotion, driving, lifting, standing or sitting

Revocation Section:

I,_____
(Patient'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 Patient, please indicate your relationship to the Patient and attach any required documentation confirming your authority to act for the Patient:* _____

Instructions for Attestation Regarding a Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care

Information for the Person Requesting the PHI

- By signing this attestation, you are verifying that you are not requesting PHI for a prohibited purpose and acknowledging that criminal penalties may apply if untrue.
- You may not add content that is not required or combine this form with another document except where another document is needed to support your statement that the requested disclosure is not for a prohibited purpose. For example, if the requested PHI is potentially related to reproductive health care that was provided by someone other than the covered entity or business associate from whom you are requesting the PHI, you may submit a document that supplies information that demonstrates a substantial factual basis that the reproductive health care in question was not lawful under the specific circumstances in which it was provided.

Information for the Covered Entity or Business Associate

- You may not rely on the attestation to disclose the requested PHI if any of the following is true:
  - It is missing any required element or statement or contains other content that is not required.
  - It is combined with other documents, except for documents provided to support the attestation.
  - You know that material information in the attestation is false.
- A reasonable covered entity or business associate in the same position would not believe the requestor's statement that the use or disclosure is not for a prohibited purpose as described above.
- If you later discover information that reasonably shows that any representation made in the attestation is materially false, leading to a use or disclosure for a prohibited purpose as described above, you must stop making the requested use or disclosure.
- You may not make a disclosure if the reproductive health care was provided by a person other than yourself and the requestor indicates that the PHI requested is for a prohibited purpose as described above, unless the requestor supplies information that demonstrates a substantial factual basis that the reproductive health care was not lawful under the specific circumstances in which it was provided.
- You must obtain a new attestation for each specific use or disclosure request.
- You must maintain a written copy of the completed attestation and any relevant supporting documents.

Attestation Regarding a Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care

The entire form must be completed for the attestation to be valid.

Name of person(s) or specific identification of the class of persons to receive the requested PHI.
Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure.
Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose protected health information you are requesting.

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (check one box):

☐ The purpose of the use or disclosure of protected health information is **not** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ The purpose of the use or disclosure of protected health information **is** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was **not lawful** under the circumstances in which it was provided.

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

Signature of the person requesting the PHI

_____ Date _____

If you have signed as a representative of the person requesting PHI*, provide a description of your authority to act for that person.*

_____