Primary Care Medical Center of Gulfport, PLLC
15444 Dedeaux Road, Suite B
Gulfport, MS 39503
Phone: (228) 832-9038 Fax: (228) 832-9990
Email: info@primarycaregpt.com

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize **Primary Care Medical Center of Gulfport, PLLC** (covered entity) to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requestor Name ______________________________

Phone Number ____________________ **Fax Number** ____________________

Address ______________________________

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Patient Information

Name ______________________________
Date of Birth ______________________________
Social Security Number ______________________________
Address ______________________________

Disclose the following PHI for treatment dates ________________ to ________________

☐Abstract/Pertinent ☐History & Physical ☐Discharge Summary ☐Consult
☐Operative Report ☐Progress Notes ☐Physician Orders ☐Nurses Notes
☐ER Report ☐Lab ☐X-ray Report ☐Entire Chart
☐Other specified______________________________

The above information is disclosed for the following purposes:
☐Medical Care ☐Legal ☐Personal ☐Other______________________________

_________ **I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse,**
Initials **psychiatric, HIV or genetic information.**

This authorization shall expire upon this expiration date ______________________________
If I fail to specify an expiration date or even, this authorization will expire six (6) months from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Primary Care Medical Center of Gulfport. I understand that the revocation will not apply to information that has already been released to this authorization.

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated.

____
(NAME OF PATIENT)

______________________________ ______________________________
(DATE) (SIGNATURE OF PATIENT)

______________________________ ______________________________
(SIGNATURE OF PATIENT REPRESENTATIVE) (RELATIONSHIP TO PATIENT)
(Required if the patient is a minor or adult unable to sign form)