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 _____ (covered entity) to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Facility Phone and/or Fax Number _____

Requestor Name **Primary Care Medical Center of Gulfport, PLLC**
Phone Number **(228) 832-9038** **Fax Number** **(228) 832-9990**
Address **15444 Dedeaux Road, Suite B**
Gulfport, MS 39503

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_____

_____ **Initials** **I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, 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)