314 Main Street Suite D
P.O. Box 1400
Monticello, MS 39654
(601) 587-4304 Main
(601) 587-4515 Fax

Caring Hands
Children's Clinic, LLC
Authorization for Release of Health Information

PATIENT NAME _____**DOB**_____
ADDRESS_____
MAIN PHONE_____**ALT. PHONE**_____

I hereby authorize the release of the following records:
_____ Immunization Records Only
_____ Labs Only
_____ Include Mental Health/Substance Abuse Records
_____ Other: _____
_____ **COMPLETE MEDICAL RECORDS** (Including Mental Health/HIV/AIDS/STD/Drug & Alcohol/Psychotherapy Records)
Records to exclude from this request—please check the appropriate areas not included in your request
□ Mental Health Records-including depression
□ Drug and/or Alcohol use/abuse
□ Other: _____

From: _____
(name of physician or clinic)

_____
(mailing address)

_____ _____ _____
(city) (state) (zip code)
FAX #_____

To: Caring Hands Children's Clinic, LLC
P. O. Box 1400
Monticello, MS 39654
601-587-4515 (fax)

I understand that:
- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization in writing or unless an earlier date is specified here: _____. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request the clinic or department where my Authorization was made or given. A photocopy is as valid as the original.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient if age 18 or older: _____ Date:_____/_____/_____
If you are NOT the patient but are signing on behalf of the patient, please complete below:

I, _____, am the _____Parent with Parental Rights or _____Court Appointed Guardian (Must provide legal documentation)

Representative's Signature: _____ Date: _____
Relationship to Patient:_____