MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
CYPRESS RIDGE BUILDING • 1867 CRANE RIDGE DRIVE, SUITE 200-B • JACKSON, MS 39216
(601) 987-3079
WWW.MSBML.MS.GOV

FAX NOT ACCEPTABLE

APPENDIX D

PERPETUAL AUTHORIZATION TO RELEASE INFORMATION

Name of Applicant	

The undersigned applicant for a physician assistant license in the State of Mississippi, hereby authorizes each educational institution at which the undersigned has applied for any license, permit, certificate or registration; each person, firm, corporation, clinic, office, or institution by whom or with whom the undersigned has been employed as a physician assistant; each insurance company with which the undersigned has obtained or made application for medical malpractice liability insurance; each physician or other health care practitioner with whom the undersigned has consulted or seen for diagnosis or treatment; and each professional organization or specialty board to which the undersigned has applied for membership, to disclose and release to the Mississippi State Board of Medical Licensure, 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216, any and all information and documentation concerning the undersigned which the Board deems material for consideration of his/her application. Further, the undersigned hereby consents to the disclosure and release of such information and documentation to the Mississippi State Board of Medical Licensure and waives any privilege or right of confidentiality which the undersigned would otherwise possess with respect thereto.

The undersigned hereby authorizes any person, firm, corporation, clinic, office, institution, state or federal agency from whom the Mississippi State Board of Medical Licensure has requested information to rely on a copy of this release, the original now on file in the office of the Mississippi State Board of Medical Licensure at the above noted address.

The undersigned also agrees to execute any other release or authorization, the execution of which may be required under federal or state law prior to release of any of the documents or information requested. Otherwise, this authorization shall constitute a complete and perpetual release and authorization for all purposes set forth therein.

Signature of Applicant			
Printed Name of Applicant		Signature Date	

Sworn to and subscribed to before me this the ____________ day of ____________________, 20____.

My Commission Expires:	______________________________ Notary Public

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

Please fill in all applicable spaces and return to the Mississippi State Board of Medical Licensure at the above address. A fax is not acceptable.