MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

For Every Patient. For Every Provider. For Every Mississippian.

HIPAA Authorization to Release Information

I, _____ (patient name), hereby authorize _____ (name of hospital, doctor's office, or facility), agents, representatives, or employees to release to the Mississippi State Board of Medical Licensure, 805 S. Wheatley Street, Suite 600, Ridgeland, MS 39157, all records or information concerning any treatment which I may have received or evaluation for any illness or condition, physical or mental. I request that this information be disclosed to the Mississippi State Board of Medical Licensure for whatever purpose the Board may deem necessary.

Any entity or person to whom this release is presented by the Mississippi State Board of Medical Licensure is authorized to rely solely on a copy of this release, thereby authorizing the Mississippi State Board of Medical Licensure to retain the original on file.

Patient Information

Patient Name (First, Middle, Last)		
Mailing Address		
City	State	Zip Code
Social Security Number	Date of Birth (MM/DD/YYYY)	
Relationship with Patient		

Signature of Patient or Authorized Person	Date

NOTE TO PROGRAM RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR, Part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.