MISSISSIPPI DEPARTMENT OF CORRECTIONS ("MDOC")
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("PHI")

- **YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY SUBMITTING A WRITTEN REQUEST TO PRIVACY OFFICER AND GENERAL COUNSEL, MISSISSIPPI DEPARTMENT OF CORRECTIONS 301 NORTH LAMAR STREET. JACKSON, MS 38201.**
- **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION AND MDOC MAY NOT CONDITION TREATMENT OR ELIGIBLITY FOR HEALTHCARE ON WHETHER YOU SIGN THIS AUTHORIZATION.**
- **MDOC WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION**.

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY REQUESTOR OR REQUESTOR'S PERSONAL REPRESENTATIVE

I, _____, ("Requestor"), Date of Birth _____, do hereby authorize MDOC to disclose my PHI as set forth below. I understand that this authorization is voluntary. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

I authorize MDOC to disclose my PHI to:

Name:_____
Address:_____
City: _____ State: ____ Zip Code: _____

MDOC may disclose the following information from my medical record to the recipient above:

- ☐ Complete medical record
- ☐ All office notes
- ☐ All laboratory/radiology reports
- ☐ All CD images / films
- ☐ Other (specify documents and date range of documents to be released)_____
  _____
  _____

The purpose or need for the information is:

_____

I understand that I may withdraw my authorization in writing to the Privacy Officer of MDOC at any time, except to the extent that action has been taken in reliance on this statement. I understand

that even if I do not withdraw authorization that this statement will expire upon ***(insert date or expiration event).*** I have carefully read and understand the above and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records and billing records of my condition to the recipient(s) listed above.

Printed Name: _____

Signature: _____ _____

- ☐ If signatory is the personal representative of the patient, check this box and check the description of the personal representative's authority to act for the requestor/relationship to the requestor:
  - ☐ Parent
  - ☐ Legal guardian
  - ☐ Personal legal representative
  - ☐ Other (please specify): _____