Mississippi Department of Human Services
Division of Youth Services
Health Services

Oakley Youth Development Center- Health Clinic

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____to use or disclose the following protected health information from the medical records of the patient listed below to:

Requestor Name: Oakley Medical Clinic
Requestor Address: 2375 Oakley Road
Raymond, Ms 39154
Phone Number: 601-857-7647 Fax Number: 601-857-5469

Patient Name:_____

Patient DOB:_____

Patient Social Security Number:_____

Patient Address:_____

Disclose the following PHI for treatment dates _____to_____
_____Abstract/Pertinent____History & Physical____Discharge Summary_____X- Ray____Operative Report
_____Progress Notes_____Physicians Orders_____Consult_____Nurses Notes_____ ER Report
____Lab _____Entire Chart _____Other Specified _____

The above information is disclosed for the following purpose: **Continuation of medical and psychiatric care while at Oakley Youth Developmental Center.**

_____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 on this date:_____***If I fail to specify an expiration date or event, 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 written to Oakley Youth Development Center. I understand that the revocation will not apply to information that has already been released to the authorization.

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected. I authorize the disclosure of the PHI as stated.

_____
Signature of Legal Representative/ Relationship to patient: Guardian Date

_____
Signature of Witness Date