PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize _____, _____ to use and/or disclose certain protected health information (PHI) about me to:

Dr. Mal S. Riddell
P.O. Box 1263
Grenada, MS 38902-1263

Fax: 662-226-0018

This authorization permits _____ to use or disclose the following identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

_____

This authorization will expire on _____.
Expiration Date

PATIENT NAME

_____

DATE OF BIRTH

_____

SOCIAL SECURITY NUMBER

_____

_____ _____
Signature of Patient or Legal Guardian Relationship

_____ _____
Print Name of Patient or Guardian Date

_____
Print Name of Patient