Meridian Surgery Center
2100 13th Street
Meridian, MS39301
601.485.4443

Authorization for Release of Patient Medical Information

I hereby request and authorize Meridian Surgery Center to release the health records of:

(Name/Label)

❒ **All general medical records, excluding HIV/AIDS, substance abuse, and psychiatric records.**
❒ **Limited records** (please specify lab results, EKG, etc.).

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Release information to:

Name/Agency: ____

Address:____

City/State/Zip: ____

Telephone: ______________________Fax No: ______________________

____ ______________________
Signature of Patient or Authorized Representative **Date**

Authorized Representative: ❒ Parent ❒ Surviving Spouse
❒ Legal Guardian/Administrator/Executor*

**If Legal Guardian, Administrator, or Executor of Estate, legal proof of this status must accompany this authorization.*

The patient or authorized representative may revoke this authorization at any time after it is signed by submitting a written request to the facility. This authorization will expire automatically 60 days after the date signed.

Prohibition on Re-Disclosure

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the express written consent of the person to whom such information pertains, or as otherwise permitted by state law. With regard to HIV/AIDS, substance abuse, or psychiatric records, a specific written consent is required — a general authorization for the release of medical or other information is NOT sufficient for this purpose.
In the event these records are being requested other than for the personal use of the patient or an attending physician, a charge of $1.39 per page will be assessed in accordance with Mississippi State Statue.