

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION
(IN COMPLIANCE WITH THE HIPPA PRIVACY RULE)

To: _____

For informational purposes pertaining to an insurance claim, I authorize and request the Custodian of Records at the above named entity to disclose to the agents or designees of **Cannon Cochran Management Services (CCMSI)**, any and all records containing **Protected Health Information (PHI)** regarding:

_____, DOB: _____, and SS#: _____
whether created before or after the date of signature. This authorization should also be construed to permit agents or designees of **Cannon Cochran Management Services (CCMSI)**, to copy, inspect and review any and all such records. Records containing **PHI** may include, but are not limited to:

All medical records, physician's records, surgeon's records, x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films, pathology materials, slides, tissues, physicals and histories, laboratory reports, operating room records, discharge summaries, progress notes, patient in take forms, consultations, prescriptions, nurses' notes, birth certificate and other vital statistic records, communicable disease testing and treatment records, correspondence, psychiatric records, psychological records, psycho-therapy notes, prescription records, medication records, orders for medications, therapists' notes, social worker's records, insurance records, consent for treatment, statements of account, itemized bills, invoices and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement.

Unless revoked in writing, this authorization shall be valid for one (1) year from the date of signature. In addition, a copy of this authorization may be used in place of and with the same force and effect as the original.

NOTICE

- The individual signing this authorization may request the entity provide them with both a copy of the authorization and a copy of the protected health information **PHI** to be disclosed.
- The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing, except to the extent that the entity has already relied upon this Authorization to disclose protected health information **PHI**.
- This authorization only applies to protected health information **PHI** already disclosed by the above named entities. This information could be re-disclosed by the receiving parties; in such case, the disclosed **PHI** will no longer be protected by the **HIPAA Privacy Rule**.

I have read this Authorization and understand that it will permit the entity identified above to disclose **Protected Health Information (PHI)** to **Cannon Cochran Management Services (CCMSI)**.

Signature

Name *(Please print)*

Date

Address

City/State/Zip