SINGING RIVER HOSPITAL SYSTEM

OCEAN SPRINGS HOSPITAL | SINGING RIVER HOSPITAL

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Patient Name: _____ **SSN:** _____

Date of Birth: _____ **MR#** _____

Effective as of April 14, 2003

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information:

Singing River Health System, Kare-In-Home, Ocean Springs Nursing Center, Singing River Rehab, Burnham's Drug Store, River Chase, Sunplex Nursing Center

2. Persons/organizations authorized to receive the information:

Coastal Mississippi Healthcare Fund, Inc.

3. Specific description of information that may be used or disclosed:

Financial and medical information needed to assess if patient meets CMHF charity guidelines and to transfer patients

4. The information will be used/disclosed for the following purposes:

Financial and medical information needed to assess if patient meets CMHF charity guidelines and to transfer patients

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

6. The person/organization authorized to use/disclose the information will receive compensation for doing so.
   Yes☐ No☒

7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this authorization at any time by notifying the person/organization providing this the information in writing, except to the extent that:

   a. action has been taken in reliance on this authorization; or
   b. if this authorization is obtained as a condition for obtaining insurance coverage, other laws provides the insurer with the right to contest a claim under policy.

9. This authorization expires (upon) _____ (Insert applicable date or event)

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative or Authority to act for the patient Relationship to patient

SRHS Employees: A copy of this signed form will be provided to the patient.