Rankin Children's Group, PLLC

1405 Crossgates Drive, W., Brandon, MS 39042 • 601-825-0925
151 East Metro, Suite 102, Flowood, MS 39232 • 601-992-2292
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Authorization to Release Medical Records/Information

*****PLEASE FILL IN COMPLETELY*****

Physician or Clinic to provide records: _____

City/State: _____Office #:_____ Fax #: _____

Patient's Full Name: _____

Street or P. O. Box:_____City/State/Zip:_____

Social Security Number: _____ Date of Birth: _____

Please indicate which location you prefer your medical records to be mailed to by marking "X" below:

☐ **Rankin Children's Group, PLLC**
1405 Crossgates Dr. West
Brandon, MS 39042
Fax: 601-825-0926

OR

☐ **Rankin Children's Group, PLLC**
151 East Metro Suite 102
Flowood, MS 39232
Fax: 601-709-2193

Release these records: Initials

1. Only records generated by this facility (not including records received from other sources). _____
2. Only some portion of records maintained at facility (date of treatment, etc. or specify below). _____
3. **ALL** Medical Records at this facility including records from other clinics/doctors. _____

For #2 above _____
_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release information specified to Rankin Children's Group, PLLC, with the exception of: (PLEASE INITIAL FOR EXCEPTION).

_____ Substance Abuse, if any _____ Psychological or psychiatric conditions, if any
_____ AIDS/HIV, if any _____ Other (please specify) _____

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified, it will automatically expire twelve (12) months after the date affixed below.
Use of Copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Person Authorized to sign for patient (print name): _____

Relationship to Patient: _____ My Telephone Number: _____

Signature of Authorized Person: _____ Date: _____