MEDICAL ANALYSIS

**1025 Division Street, Biloxi, MS 39530**
**(228) 388-2599 PH (228) 388-9861 FX**

Please Mark (x) on the proper release request.

**_____I, _____give Medical Analysis permission to release my medical information to include all documentation to the following:**

**Name: _____ Phone #: _____**

**Address: _____ Fax #: _____**
**_____**
**_____**

**I understand that this authorization is voluntary. Medical Analysis will not condition my treatment/health care services on completing and signing this authorization. I understand that if the organization authorized to receive the information is not a health care provider or health plan, that organization may also disclose my health information. Should this occur, I understand that my information may no longer be protected by federal privacy regulations.**

**I understand that I may revoke this authorization at any time by notifying Medical Analysis in writing.**

**I understand that the information outlined in this release will be disclosed according to the instructions of this release within five business days of Medical Analysis receiving this release authorization.**

**This authorization will expire on: _____ or six months from authorization date**

_____ _____ _____
**Patient's Name (Please Print)** **Patient's S.S.N.** **Patient's D.O.B.**

_____ _____
**Signature of Patient or Patient's Legal Representative** **Date**

_____ _____
**Printed Name of Patient's Legal Representative** **Representative's Authority**

_____ _____
**Witness Signature** **Date**