OLIVE BRANCH MEDICAL

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This authorization authorizes the release of Protected Health Information pursuant to 45 CFR 160 and 164 and any information sensitive under 42 CFR.

PROVIDER _____

ADDRESS _____

1. The undersigned authorizes the above named provider, hereinafter referred to as "Provider" to release any and all information (including billing statements) regarding my condition while under Provider's observation or treatment; including history, findings and observations, conclusions, x-ray readings and diagnosis, and any prognosis as to subsequent or future treatment. You may also release any and all myelograms, x-rays, CAT scans or MRI images for independent examinations.

2. The information may be disclosed by employees or business associates of Provider.

3. The above information may be disclosed to Olive Branch Medical, LLC, their representatives, employees, business associates and contractors for independent examination. Disclosure may be made in writing only and you may allow them to photocopy my records.

4. Patient does acknowledge: (1) that I have the right to revoke the authorization at any time, and (2) that I understand that once the information is disclosed, it may no longer be protected by the Federal Privacy Standards.

Patient may revoke this authorization only in writing by hand delivering a copy of the same to the provider, or by sending the same certified mail, at the address hereon. The revocation will be effective only upon receipt, except (1) to the extent the Provider has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest any claim.

5. I understand that treatment by the Provider is not conditioned on my signing this authorization, although exceptions will be made for (a) research related treatment; (b) for treatment the purpose of which is creating protected health information for a third party, such as re-employment physicians; (c) except for psychotherapy notes for health plans who condition enrollment or on an authorized request prior to enrollment, or where payment is conditioned on an authorization to us PROTECTED HEALTH INFORMATION to determine payment

6. Provider warrants that this authorization will not be used for marketing or disclosure of any type to any third party.

7. It is agreed that a photocopy of this Authorization is to have the same force and effect as the original.

Patient's Signature _____ Date _____

Patient's Name (please print) _____