LANDMARK INTERNAL MEDICINE
7615 Clarington Cove,
Southaven, MS 38671
Phone: (662) 536-2500 Fax: (662) 536-2505

Authorization For Release of Patient Health Information

I hereby authorize the release of information from the medical records of:

Patient's Name: _____ Date of Birth: _____

Please choose one of the following:

__*Patient records will be released from LANDMARK INTERNAL MEDICINE to*

Name:_____

Address:_____

City: _____ State: _____Zip:_____

Phone: _____ Fax: _____

The records will be:
__ Mailed to address above.
__ Picked up at LANDMARK INTERNAL MEDICINE by the person listed above.

OR

__ *Patient records are to be released to LANDMARK INTERNAL MEDICINE from*

Practice or Provider Name: _____

Address:_____

City: _____ State: _____Zip: _____

Phone: _____ Fax: _____

The records will be:
__ Mailed to address: ***303 BROOK AVE***, ***BRONX, NY 10454-2508***
__ Faxed to ***347-590-6564***
__Other, please specify:
_____

Information to be Released:
__ Well-visit
__Immunization record
__Growth Charts
__ Entire health record
__ Records relating to behavioral, developmental and mental health care
__ Records relating to communicable diseases, HIV or AIDS
__ Records relating to diagnosis and treatment of alcohol/drug abuse
__Other, please specify: _____
OR I hereby authorize the release of my complete health record with the exception of the following information:
__ Mental health records, including behavioral and developmental
__ Communicable diseases, including HIV and AIDS
__ Alcohol/drug abuse diagnosis and treatment
__ Other, please specify: _____

For dates from _____ to _____
Mo/Day/Yr Mo/Day/Yr

Reason for Release: __ Specialty care __ ER visit __ Hospital admission __Continuity of Care
__ Other, please specify:
_____

Informed Consent for Release of Confidential Information

- The expiration date or expiration event for this authorization is upon delivery of the requested records.
- I understand I have the right to revoke or withdraw the release of medical records as long as the release of records has not taken place, and I have let my revocation/withdrawal be known to LANDMARK INTERNAL MEDICINE in writing and prior to the release. The request to revoke authorization must contain the signature of the patient, parent, legal guardian or the patient's legal representative
- I understand I have the right to review the medical records prior to release from LANDMARK INTERNAL MEDICINE. I understand that by signing this authorization without the request to review the medical records means I have waived my right to review the medical records that are to be released by signing this authorization.
- I understand that signing this authorization is completely voluntary, and I have the right to refuse to sign this authorization. The treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.
- I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered under Title 42 of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of this information.
- I understand that the federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- This authorization also includes any information related to diagnosis and/or treatment of any genetic condition, psychiatric or mental illness, communicable diseases, and/or any state of infection with the HIV (AIDS) virus.
- I understand that the medical records contain information that only a physician can interpret.
- I understand that I am to consult the physician regarding the contents of the medical record if I have any questions or concerns about the contents, and that this is to avoid misunderstanding of the contents.
- I understand that if I choose not to consult the physician regarding the contents of the medical record, I will not hold LANDMARK INTERNAL MEDICINE liable for the misinterpretation of the contents of the medical record.
-LANDMARK INTERNAL MEDICINE hereby is released from all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under applicable federal or state laws.
- I understand that any further disclosure or release of the medical records by LANDMARK INTERNAL MEDICINE is prohibited and will require repeat written consent and authorization, or as permitted by 42 CFR Part 2.
- This authorization covers materials capable of being reduced to printed form.
- The requested records are for only the purpose indicated on this authorization form.

I authorize the use or disclosure of information specified in this authorization regarding the patient named above.

_____

Printed Name of Parent, Legal Guardian or Patient *(if meeting specific legal criteria)*

_____

_____Signature of Parent, Legal Guardian or Patient *(if meeting specific legal criteria)*

/ /2026 AM/PM ( )

Date: Time: Phone number