☐ **Forrest General Hospital**	☐ **Jeff Davis Community Hospital**
☐ **Highland Community Hospital**	☐ **Walthall Community Hospital**
☐ **Marion General Hospital**	☐ **Ambulatory Clinic:**_____

Forrest Health Request from Law Enforcement for Release of Protected Health Information

Any information regarding a Pine Grove patient requires a Court Order or Warrant

All requests require: *Completed Request from Law Enforcement for Release of PHI form and Picture ID.*

PATIENT INFORMATION				
☐ **Suspect**	☐ **Fugitive**	☐ **Material Witness**	☐ **Missing Person**	☐ **Victim**

Patient's Name _____ Date of Birth_____ and/or
(Last, First, Middle)
Other identifying information:_____

REQUESTING AGENCY INFORMATION

Name of Law Enforcement Official_____ Badge # _____

Department _____ Phone _____ Fax _____

Requested Information related to an active law enforcement investigation:

_____

_____

Please check the appropriate legal exception to the Health Insurance Portability and Accountability Act (HIPAA) that will all the requested information to be released:

☐ **Suspect, Fugitive, Material Witness, or Missing Person.** I certify that the information about the above named patient is needed to assist in attempting to identify or locate a suspect, fugitive, material witness, or missing person. I understand that the information I can obtain is limited under federal law. (45 CFR §§ 164.512(f)(2).)
PERMITTED DISCLOSURE INCLUDES THE FOLLOWING: (1) name and address; (2) date and place of birth; (3) social security number; (4) ABO Blood type and rh factor; (5) type of injury; (6) date and time of treatment; (7) date and time of death, if applicable; and (8) description of distinguishing physical characteristics, including weight, gender race, hair and eye color, presence or absence of facial hair (beard or moustache), scars and tattoos, if known. **NO OTHER PHI MAY BE DISCLOSED.**

☐ **Victim of a Crime.** The information sought concerns a possible victim of a crime in a situation not otherwise covered by other categories on this form. **Either the suspected victim's written agreement to the disclosure is attached to this form, or I request that appropriate personnel seek the victim's agreement to the disclosure**. If the victim's agreement cannot be obtained due to incapacity or other emergency circumstance, I certify that the information is needed to determine whether a violation of law by someone other than the victim has occurred, that the information is not intended to be used against the victim, and that the investigation would be materially and adversely affected by waiting until the patient is able to agree to the disclosure. I understand that the disclosure is subject to a determination of what is in the best interests of the patient in the exercise of professional judgment by medical professionals.

☐ **Crime on Premises.** The information sought constitutes evidence of possible criminal conduct occurring on the premises of Forrest General Hospital.

☐ **Patient Authorization**. I have received written authorization from the patient for the release of medical information. A copy of the dated release with patient signature is attached.

_____ _____/_____ _____
Signature of Law Enforcement Official **Date / Time** **Printed name of Law Enforcement Official**

Please fax completed form and verification of identity and authority of Law Enforcement Official to 601-288-4355

To be completed by FGH:

FGH PD IR#	FGH PD OFFICER	FGH PD OFFICER ID
MRN #	PATIENT NAME:	DATE OF BIRTH:
REQUESTER IDENTITY VERIFIED? ☐ YES ☐ NO		DATE INFORMATION RELEASED:
INFO RELEASED VIA PHONE (Exigent circumstance), UNABLE TO OBTAIN PATIENT'S SIGNATURE. ☐ YES ☐ NO		
PROTECTED HEALTH INFORMATION RELEASED:		