



1. Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Phone (Day): \_\_\_\_\_ (Eve): \_\_\_\_\_ Med Rec # (if known): \_\_\_\_\_

2. I give my permission to share my protected health information from my medical record as indicated below

<b>FROM:</b> (Hospital/provider you would like to send records) Name: _____ Address: _____ _____ Fax #: _____ Phone #: _____	<b>TO :</b> (Who should receive records. Patients requesting their own record can list "SELF".) Name: _____ Address: _____ _____ Fax #: _____ Phone #: _____
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3. Purpose:  Medical Care  Insurance  Legal Matter  Personal  School  Other (specify): \_\_\_\_\_  
(Please check the appropriate purpose. **Please note that record requests may be subject to a copying fee.**)

Leaving **South Shore Health System**/ Date effective: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Reason Leaving: \_\_\_\_\_  
(Note: All appointments, orders and referrals after the transfer date will be cancelled)

4. Information to be released for treatment dates: **From:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Through:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- Abstract** (Includes History & Physical, Operative Reports, Consults, Test Results, Discharge Summary, etc)
- Discharge Summary       X-Ray/Radiology Reports       Emergency Reports
- History & Physical       Laboratory Reports       Films/CD (x-ray, MRI, CT Scan, etc)
- Pathology Results       Therapy(Physical /Occupational)       Complete record (Not including films. Addtl. time needed)
- Consults       Outpatient Notes       Other \_\_\_\_\_

5. Privileged or specifically protected information to be released if present in the patient record

**Release of Information Requiring Specific Consent:** The following categories of information in your medical record **WILL NOT** be released without your specific authorization, indicated by initialing each appropriate category.

\_\_\_\_ Abortion    \_\_\_\_ HIV/AIDS Results/Treatment    \_\_\_\_ Genetic Testing    \_\_\_\_ Sexually Transmitted Diseases    \_\_\_\_ Behavioral / Mental Health

\_\_\_\_ Domestic Violence Victim's Counseling    \_\_\_\_ Sexual Assault Victim's Counseling    \_\_\_\_ Communication with a licensed Social Worker

\_\_\_\_ Drug and/or Alcohol Abuse

**STOP** Please confirm that you have initialed all categories that may be contained in your record to authorize their specific release.

I understand that:

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at SSHS unless (a) the only purpose of the treatment is to create health information for the disclosure noted above; or (b) if my treatment is related to participation in a research study for which this authorization is required.
- I may revoke this authorization at any time by submitting a written notice of revocation to SSHS at the address listed above. The revocation will be effective upon SSHS's receipt of my written notice; however, it will not have any effect on any actions already taken by SSHS in reliance on this authorization.
- Once SSHS has disclosed my health information to an authorized recipient, SSHS cannot guarantee that the recipient will not redisclose my health information to a third party.
- This authorization will automatically expire 6 months from the date set forth below unless otherwise specified: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Legal Representative

\_\_\_\_\_  
Relationship to patient or authority to act for patient

## INSTRUCTIONS:

The Authorization to Use or Disclose Protected Health Information form has a dual purpose. It can be used when requesting medical records be released from South Shore Health System or when requesting that medical records be sent to any entity within South Shore Health System. The form is generally used when the patient him/herself is required to authorize the release or disclosure of medical record information.

1. Please provide patient identifying information, including full name, date of birth, street address, contact information and medical record number (if known).
2. In the FROM Box, indicate the entity or clinician that is providing the records (typically, "South Shore Health System"). In the TO Box, indicate the entity or individual to whom you would like the records released (for example: "Self" or "Doctor's Office" or "Attorney's Name" or "Insurance Company Name")
3. Indicate the purpose for which you would like the records released. Please note that record requests may be subject to a copying fee
4. Indicate the treatment dates for which you would like the records released. (For example, "Jan 1, 2014 to present."). Also indicate what type of records you would like released.
5. In order for this information to be released, you **must** initial each item listed.
6. Please sign and date the form. Information cannot be released without an appropriate authorized signature.

*If you have any questions please contact our office.*

*Thank you!*