South Shore Health System

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Home Care Division
30 Reservoir Park Drive
Rockland, Ma 02370
781-624-7070

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

FROM: (Hospital/provider you would like to send records)	**TO :**(Who should receive records. Patients requesting their own record can list "SELF".)
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Fax #: _____	Fax #: _____
Phone #: _____	Phone #: _____

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!