South Shore Medical Center
part of South Shore Health

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

South Shore Medical Center
P.O. Box 9147
Norwell, Ma 02061
781-261-4417

1. **Patient Last Name:**_____ **First Name:**_____ **DOB:** _____

Patient Street Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Patient Phone:_____ **Medical Record Number (if known):** _____

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

FROM:	**TO:** (recipient of records. Note '**self**' if sending to patient address
❍ South Shore Medical Center ❍ Other: (specify below)	Name: _____
Name: _____	Address: _____
Address: _____	_____
_____	Phone#: _____
Phone#: _____	Fax#: (For Health Care Facilities/Providers) _____
Fax #: _____	**HIM Method of Record Delivery (Choose One):**
Purpose:	❍ Email: _____
❍ Medical Care ❍ Personal*	❍ South Shore Health MyChart (if applicable)
❍ Insurance* ❍ Other (specify)* _____	❍ Paper Copy sent via mail to the address noted above.
❍ Legal Matter* ***Copying fees may apply**	❍ CD sent via mail to the address noted above.

3. **If leaving South Shore Medical Center – Date Effective: ____/____/____ , Reason Leaving: _____**
(Note: All appointments, orders and referrals after the transfer date will be cancelled)

4. **Complete Section if applicable:**
   - ❍ **2-Way <u>Verbal</u> Communication with your treatment team for all records and all dates of service unless specified below:**

5. **Complete Section if applicable for releasing medical records:**
Information to be released for treatment dates: From:_____/_____/_____through:_____/_____/_____
I authorize the disclosure of the following information which may be included in my record. Specify records, by checking.

❍ Abstract (Includes History & Physical, Operative Reports, Consults, Test Results, Discharge Summary, Emergency Reports)		
❍ Discharge Summary	❍ X-Ray/Radiology Reports	❍ Emergency Reports
❍ Mental Health Consult	❍ Laboratory Reports	❍ CD *(X-Ray, MRI, CT Scan)*
❍ Mental Health Progress Note	❍ Therapy *(Physical/Occupational)*	❍ Complete Record *(Not Including CD)*
❍ Addiction Medicine Consult	❍ Consults	❍ Outpatient Notes
❍ Addiction Medicine Progress Note	❍ Pathology Results	❍ Other Specify):_____

6. **Privileged or specifically protected information requires specific consent when present in the patient record:**

I am authorizing the release of the following information by **<u>INITIALING</u>** each appropriate category.

_____Alcohol and Drug Abuse
I understand that if my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, they cannot be disclosed without my written consent unless otherwise provided for in the regulations.

_____Mental Health	_____Communication with a licensed Social Worker	_____Domestic Violence Victim's Counseling
_____HIV/AIDS/Results/Treatment	_____Sexual Assault Victim's Counseling	_____Abortion
_____Sexual Transmitted Diseases	_____Genetic Testing	

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Patient Last Name:_____ **First Name:**_____ **DOB:**___/___/____

7. Required Information:

OTHER IMPORTANT INFORMATION

1. I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at South Shore Health (SSH) 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.

2. Once SSH has disclosed my health information to an authorized recipient, SSH cannot guarantee that the recipient will not re-disclose my health information to a third party.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider before the Provider received written notice of revocation. I further understand that I must provide any notice of revocation in writing to the Privacy Officer of South Shore Hospital at 55 Fogg Road, Mailbox #82, South Weymouth, MA02190.

4. Unless otherwise revoked, this authorization will expire within one year or on the following date, event, or condition:

_____

***5*. I understand that I may be charged a fee for reproduction of requested health information. This fee will comply with Massachusetts Law Chapter 111, § 70 with regard to the inspection and copying of medical records.**

6. If I have any questions about disclosure of my health information, I can contact **Health Information Management Department at (781) 261-4417. The completed form can be mailed to Health Information Management Department, P.O. Box 9147, Norwell, Ma 02061 or faxed to (781) 878-5044.**

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to patient or authority to act for patient

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION 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 or when requesting that medical records be sent to any entity within South Shore Health. The form is generally used when the patient or appointed legal representative is required to authorize the release or disclosure of medical record information.

*Please note that record requests may be subject to a copying fee.

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 Medical Center”). Here you will also indicate the purpose or reason for the request.

   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"). Also indicate the manner in which you would like to receive the requested information; email, South Shore Health MyChart, mail, fax (only applicable for Healthcare Facilities and/or providers) or CD.

3. If applicable to your request, enter the date you are leaving our care and the reason in the ‘Leaving South Shore Medical Center’ section.

4. Complete this section for 2-Way Verbal Communication when applicable for your treatment team to communicate with other healthcare providers and/or individuals.

5. 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.

6. In order for this information to be released, you **must** initial each applicable item listed.

7. Please sign and date the form. Information cannot be released without an appropriate authorized signature.

Incomplete and/or illegible forms are not valid and will be returned for completion.

If you have any questions please contact our office.

Thank you!