

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

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

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

I am authorizing the release of the following information by **INITIALING** 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





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

5. 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, MA 02190.
4. This authorization will expire within one year unless revoked.
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) 624-8843. The completed form can be mailed to Health Information Management Department 55 Fogg Road, Box 55 S.Weymouth, MA 02190 or faxed to (781) 624-3719.**

Signature of Patient or Authorized Representative

Date

Printed Name of Patient or Legal Representative

Relationship to patient or authority to act for patient



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 South Shore Health from an outside entity. 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. 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.
4. In order for this information to be released, you must initial each applicable item listed.
5. 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!