



## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION - SHG

I hereby authorize Southcoast Hospitals Group to disclose the following protected health information from the medical record of the patient listed below. I understand that information disclosed pursuant to this authorization could be subject to **redisclosure** by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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

**Home Phone:** \_\_\_\_\_ **Alternate Phone:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Information to be disclosed to:** \_\_\_\_\_

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

**Disclose the following information for treatment dates:** \_\_\_\_\_ to \_\_\_\_\_

- Abstract  Discharge Summary  Consult  Operative Report  History & Physical  EKG  Emergency Reports
- Outpatient Reports  Laboratory  X-Ray Report  Pathology  Therapy (OT, PT, Speech, Audiology, Cardiac Rehab)
- Other Specified \_\_\_\_\_

The above information is **disclosed for the following purposes:**

- Medical Care**  **Legal**  **Insurance**  **Personal**  **Other:** \_\_\_\_\_

I understand I may **revoke this authorization** at any time by requesting such from Southcoast in writing, unless it has already been acted upon, or during a contestability period under applicable law.

This authorization **expires** upon completion of this request.

\_\_\_\_\_  
Signature of Patient or Legal Representative Date Time

\_\_\_\_\_  
Printed Name of Patient or Patient's Representative Relationship to Patient or Authority to Act for Patient

### Protected Health Information

If the information in this section pertains to your treatment, you must complete and sign for your request to be processed.

I authorize release of protected health information by checking the following:

- Psychiatric Information  AIDS/HIV Information or Test Result  Social Service Notes  Drug Treatment /Testing
- Alcohol or Test Results  Sexual Physical Abuse  Socially Transmitted Disease/Test Results  Genetic Testing

\_\_\_\_\_  
Name of Patient or Legal Representative Date Time

\_\_\_\_\_  
Name of Patient or Patient's Representative Relationship to Patient or Authority to Act for Patient

- Delivery:**  I plan to pick up at:  Charlton  St. Luke's  Tobey  
 Please send by U.S. Mail