



Authorization for release of protected health information

In order for Southcoast to provide you or your physician with a copy of your medical records, you must fully complete the attached form.

The release of protected health information is strictly regulated by the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191. To view Southcoast's Notice of Privacy Practices, visit www.southcoast.org/privacy/.

Requests can only be completed if all required signatures are included on this form.

Please allow at least three business days after receipt of your fully completed form for most routine medical record requests to be fulfilled. Urgent requests should be made in person. Fees may apply for copies of some medical records.

INSTRUCTIONS

1. Completely fill out all parts of the form, including all appropriate checkboxes for specific reports.
2. Review the Protected Health Information box and check all appropriate checkboxes.
3. Sign the report in two places. There is a large "X" where signatures are required.
4. Please indicate if you plan to pick-up the copies or have them mailed. When you provide the full name and mailing address of your physician, we will forward the copies via U.S. mail directly to your physician.
5. Mail or fax your completed form to:

Southcoast Hospitals Group
Health Information Services
101 Page Street
New Bedford, MA 02740

Fax: 508-961-5134

For further information or for questions, call Gloria at 508-961-5133.



SOUTHCOAST
HOSPITALS GROUP

Charlton ■ St. Luke's ■ Tobey
www.southcoast.org

Authorization for release of protected health information

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

Dates of treatment: _____ to _____

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

X _____
Signature of Patient or Legal Representative Date

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

X _____
Signature of Patient or Legal Representative Date

Printed 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

