Southcoast Health

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Southcoast Health to disclose the following protected health information from the medical record of the patient listed below. The records may include treatment from Southcoast Hospitals Group, Southcoast Physicians Group, Southcoast Visiting Nurse Association and/or Same Day SurgiClinic. 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. If you have any questions, please call 508-973-3733.

**A. Patient Name:** ______________________ **Date of Birth**: ______________

**Address:** ______________________________________________
(Street) (City, State) (Zip)

**Home Phone**: ______________ **Email:** ______________

**B. Information to be disclosed to:** ______________________

**Address:** ______________________________________________
(Street) (City, State) (Zip) (Fax/ Email)

**C. Format** (please select delivery method below) ☐ **Paper** ☐ **Electronic** ☐ **Verbal*** (Discussions only disclaimer)

☐ **US Mail Service** ☐ **Fax** ☐ **Patient Portal*** (Portal disclaimer) ☐ **Email*** **(**Email disclaimer)

☐ **Pick-Up Location:** ☐ Charlton Memorial Hospital ☐ St. Luke's Hospital ☐ Tobey Hospital ☐ Other ______________

**D. Disclose the following information for treatment dates: From:** ____________ **To:** ____________

☐ Abstract ☐ Discharge Summary ☐ Consult ☐ Operative Report ☐ History & Physical ☐ EKG

☐ Emergency Reports ☐ Outpatient Reports ☐ Lab ☐ Therapy (OT, PT, Speech, Audiology, Cardiac Rehab)

☐ Pathology ☐ Imaging Report ☐ Letter

☐ Other Specified ______________________________________________

☐ **Physician Practice Records Request**: ______________________________
(Physician Name)

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

☐ **Medical Care** ☐ **Legal** ☐ **Insurance** ☐ **Continuity of Care** ☐ **Other:** ______________

☐ **Claim/Appeal under Federal or State Disability, Social Security, Workers' Compensation, Veteran Benefits, or Other Needs-Based Benefit Program (**Supporting Documentation May Be Requested)

I UNDERSTAND THAT SIGNING THIS AUTHORIZATION IS VOLUNTARY AND THAT MY HEALTH CARE AT SOUTHCOAST HEALTH WILL NOT BE AFFECTED IF I DO NOT SIGN THIS AUTHORIZATION. THIS AUTHORIZATION IS VALID FOR A PERIOD OF **ONE (1) YEAR**.

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**F.** I understand I may **revoke this authorization** at any time by notifying Southcoast Health in writing, but my revocation will not affect uses and disclosures made in reliance upon the authorization prior to its revocation.

Signature of Patient or Legal Representative ____________________ Date ____________________

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

**G. Specific Authorization for Protected or Privileged Health Information**

If your records include information regarding the following types of treatment, you must CHECK EACH APPLICABLE CATEGORY to authorize the disclosure and sign for your request to be processed. If not checked, these records **will not be disclosed under this Authorization.**

☐ **Mental Health Diagnosis and/or Treatment** provided by a Psychiatrist, Psychologist, Social Worker, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Counselor (I understand that consent may not be required to release these mental health records for payment purposes).

☐ **Substance Use Disorder Treatment Records** Protected by 42 CFR Part 2 or state law. This consent may be revoked upon oral or written request.

☐ **HIV/AIDs Testing**

☐ **Genetic Testing**

☐ **Sexually Transmitted Infection/Disease**

☐ **Sexual Assault Counseling**

☐ **Physical Abuse or Domestic Violence Counseling**

Signature of Patient or Legal Representative ____________________ Date ____________________

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

**Disclaimer**: Email communications may not be secure and could potentially be read by third parties. Verbal discussions are only authorized between clinicians and parties listed on the "Information to be disclosed to" line above. Patient Portal delivery is in accordance with Southcoast Health MyChart Terms and Conditions MyChart - Login Page (southcoast.org).