



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Southcoast Health 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. If you have any questions regarding this form please call 508-973-3733.

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** **Continuity of Care** **Other:** _____

This authorization is valid for a period of one (1) year.

I understand I may **revoke this authorization** at any time by requesting such from Southcoast in writing, unless it has already been acted upon.

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:

- Mental Illness AIDS/HIV Information or Test Result Genetic Testing Drug or Test Results
- Alcohol or Test Results Sexual or Physical Abuse Socially Transmitted Disease/Test Results

Signature of Patient or Legal Representative

Date

Name of Patient or Patient's Representative

Relationship to Patient or Authority to Act for Patient

Delivery:

- US Mail Delivery**
- I Plan to pick up at:** **St. Luke's** **Charlton** **Tobey**