AuthoRelPHI

Southcoast® Health

Authorization for Release of Medical Information – Southcoast Physicians Group

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. There may be a processing fee associated with this request. Our Health Information Management staff can assist you with questions at 508-973-3776.

As you complete each step on this form, please make a check mark in the box provided to the left. Please print clearly.

Step 1 Completed ❑	**STEP 1. Information about you:** Patient: Last First Date of Birth: Address: Street City State Zip Home Phone Cell Phone
Step 2 Completed ❑	**STEP 2. Reason for requesting your medical records (please check one option):** ❑ Transfer of Care ❑ Legal ❑ Insurance ❑ Coordination of Care Other (please explain)
Step 3 Completed ❑	**STEP 3. Who has the records now?** I hereby authorize MD / DO Physician's Address
Step 4 Completed ❑	**STEP 4. To whom do you wish to release your records?** To release the following information please specify: ❑ Dates of Treatment: _____ To _____ Other _____ Release to Address
Step 5 Completed ❑	**STEP 5. Your Signature:** This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required. Signature of Patient or Patient's Representative Date
Step 6 Completed ❑	**STEP 6. Release for Sensitive Information:** **I understand that if my medical record contains information in reference to drug and/or alcohol abuse, sexual or physical abuse, genetic testing, psychiatric, venereal disease, social service, hepatitis testing/treatment, and/or sensitive information, I agree to its release.** Signature of Patient or Legal Guardian Date
Step 7 Completed ❑	**STEP 7. Release of HIV Information:** **In addition to the above signatures, if you want your HIV (AIDS) testing/treatment records released you must sign and date on the line below. I agree to the release of this information.** Signature of Patient or Legal Guardian Date

Created: 8/25/15 Reviewed: Revised: 6/15/16, 7/22/16