AuthoRelPHI

SOUTHCOAST PHYSICIANS GROUP

Authorization for Release of Medical Information – SPG Physician's Practice Records

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 508-973-3733.

Information about you:

Patient: _____ Date of Birth: _____
Last First

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

E-Mail: _____

Purpose for requesting your medical records (please check one option):

☐ Transfer of Care ☐ Legal ☐ Insurance ☐ Coordination of Care

☐ Other (Please Explain)_____

Who has the records now? (Include additional requests on reverse side)

1. I authorize: _____MD/DO

   Physician's Address:_____

2. I authorize: _____MD/DO

   Physician's Address:_____

To whom do you wish to release your records? (Yourself, Your Physician, Other)

To disclose the following treatment dates: From: _____To: _____

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Your Signature:

This authorization is valid for 1 year and may be revoked at any time by requesting in writing from Southcoast, unless it has already been acted upon.

_____ _____
Signature of Patient or Patient's Representative Date

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 Patient's Representative Date

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

Check one: Record Format: ☐ **Paper copies** ☐ **CD/DVD** ☐ **Electronic (PDF)**
Check one: Delivery Method: ☐ **US Mail Delivery** ☐ **E-mail**

Disclaimer: Email communications may not be secure and could potentially be read by third parties.

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Who has the records now?

3. I authorize: _____MD/DO

   Physician's Address:_____

4. I authorize: _____MD/DO

   Physician's Address:_____

5. I authorize: _____MD/DO

   Physician's Address:_____

Created: 8/25/15 Reviewed: Revised: 6/15/16, 7/22/16,6/13/18,2/12/19,4/2/19