AuthoRelPHI

SOUTHCOAST HOSPITALS GROUP

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**

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

☐ **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

_____ _____
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** ☐ **Verbal** (discussions only-does not authorize release of written information or copies of medical records)

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.

Revised: 5/15/03, 5/03/05, 2/28/06, 5/09, 9/09, 8/11/11, 12/8/11,5/1/14,11/7/14,7/22/16,4/2/19,3/15/21, 8/27/2021,2/02/22