South Shore Hospital

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

55 Fogg Road
South Weymouth, MA
02190-2455
southshorehospital.org
781-624-8237

1. Patient Last Name: _____ **First Name:** _____ **DOB:** ___/___/____

Patient Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Patient Phone (Day): _____ **(Eve):** _____ **Med Rec # (if known):** _____

2. I give my permission to share my protected health information from my medical record as indicated below

FROM (Hospital/provider you would like to receive records from)	**TO** (Who should receive records. Patients requesting their own record can list "SELF".)
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Fax #: _____	Fax #: _____
Phone #: _____	Phone #: _____

3. Purpose: ❍ Medical Care ❍ Insurance ❍ Legal Matter ❍ Personal ❍ School ❍ Other (specify): _____
(*Please check the appropriate purpose.* ***Please note that record requests may be subject to a copying fee.***)

4. Information to be released for treatment dates: **From:** ___/___/____ **Through:** ___/___/____

❍ **Abstract** (*Includes History & Physical, Operative Reports, Consults, Test Results, Discharge Summary, etc)*

❍ Discharge Summary	❍ X-Ray/Radiology Reports	❍ Emergency Reports
❍ History & Physical	❍ Laboratory Reports	❍ Films/CD *(x-ray, MRI, CT Scan, etc)*
❍ Pathology Results	❍ Therapy*(Physical /Occupational)*	❍ Complete record *(Not including films. Addtl. time needed)*
❍ Consults	❍ Outpatient Notes	❍ Other _____

5. Privileged or specifically protected information to be released if present in the patient record

YES	NO	***(You must check YES or NO for each of the following)***
❍	❍	HIV test results (*Patient authorization required for each release request per M.G.L. c.111 §70F*)
❍	❍	Genetics screening test results
❍	❍	Sexually transmitted diseases
❍	❍	Domestic violence victim's counseling
❍	❍	Sexual assault victim's counseling
❍	❍	Communications with a licensed Social Worker
❍	❍	Psychiatric health (*treatment information by a Psychiatrist, Psychologist, or Psychiatric Clinical Nurse Specialist)*

I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/ physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and South Shore Hospital will not condition my treatment, payment, health plan enrollment, or eligibility for benefits on my providing authorization for the requested use or disclosure. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and no longer protected by South Shore Hospital. I further understand that this authorization will automatically expire in 6 months unless otherwise specified here: _____. I have carefully read and understand the above, have had any questions answered to my satisfaction and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those listed above.

6. ✘ _____ _____ ___/___/____

Signature of Patient or Legal Representative | Print Name of Patient or Legal Representative | Date

_____
Relationship to patient or authority to act for patient (if applicable—e.g. parent, guardian, executor of estate)

THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED

See Instructions on back

INSTRUCTIONS:

The Authorization to Use or Disclose Protected Health Information form has a dual purpose. It can be used when requesting medical records be provided from South Shore Hospital or when requesting that medical records be sent to South Shore Hospital. The form generally is used when the patient him/herself is required to authorize the release or disclosure of medical record information.

1. Please provide patient identifying information, including full name, date of birth, street address, contact information and medical record number (if known).

2. In the FROM Box, indicate the entity or clinician that is providing the records (typically, “South Shore Hospital”). In the TO Box, indicate the entity or individual to whom you would like the records released (for example: "Self" or “Doctor's Office" or "Attorney’s Name" or "Insurance Company Name")

3. Indicate the purpose for which you would like the records released. Please note that record requests may be subject to a copying fee

4. Indicate the treatment dates for which you would like the records released. (For example, "Jan 1, 2014 to present."). Also indicate what type of records you would like released.

5. You **must** select YES or NO specifically for each item listed. Even if your record does not contain any of these sensitive items you must answer each question. If you request that certain information not be released the record must be reviewed prior to release and can take additional time to complete your request.

6. Please sign and date the form. Information cannot be released without an appropriate authorized signature.

If you have any questions regarding this form or your medical records,

please contact Correspondence during regular business hours,

Monday – Friday 7am-5pm, excluding holidays at 781-624-8235

Thank you…we look forward to filling your records request.