



OBSTETRICS • GYNECOLOGY • WELL WOMAN CARE

Dear Patient:

Please be aware that all fetal abnormalities cannot be detected by ultrasound. Please discuss any concerns with your provider.

Thank you.

Signed: _____

Date: _____

DARLYNE A. JOHNSON, M.D.
JULIANNE ARENA, M.D.
CHRISTINE D. HIRSEMANN, M.D.
KAREN M. TOUJOUSE, M.D.
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CYNTHIA MacLACHLAN, N.P.
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DONNA TOCCI, P.A.-C
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KRISTEN ADAMS, P.A.-C
DIANE RUTAN, N.P.
KATHLEEN ALEXANDER, N.P.

JESS F. ORRICK, ADMINISTRATION

South Shore Women's Health Family Medical Leave Act (FMLA) Release

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Maiden Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

I hereby authorize South Shore Women's Health to disclose the following health information to: **PLACE OF EMPLOYMENT**

Specific Information to be released:

1. Information to be disclosed:

Medical record from this date _____ and will expire one year from this date.

Comments: _____

2. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do NOT permit information of this type, if it exists, to be released. I understand that if I do not check the box, South Shore Women's Health will release such information.

HIV / AIDS Infection

Sexually transmitted diseases

Genetic Information

Treatment for alcohol and/or drug abuse

Mental Health

3. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

4. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying South Shore Women's Health. I understand that any previously disclosed information would not be subject to my revocation request.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here:

This form must be fully complete before signing.

Signature of Patient or Patient's Legal Representative

Date

Print Patient's Name

Print Name of Legal Representative (If applicable)

Relationship to Patient

90 Libbey Parkway, Suite #105
Weymouth, MA 02189
339-201-4120 Fax 339-201-4122

689 Bedford Street
Whitman, MA 02382
781-447-4001 Fax 781-447-4025

118 Long Pond Road, Suite #200
Plymouth, MA 02360
774-773-9976 Fax 774-283-4339