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:

____

☐ I hereby authorize __________________________________ to disclose the following health information to South Shore Women's Health

Specific Information to be released:

- Information to be disclosed:

☐ Medical record from this date __________________ to this date __________________.

☐ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology Studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Comments: ____

____

- 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

- 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. 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. 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: ____(Please print legibly)

Requested form of medical record. Please check one:

☐ Email: ____(Please print legibly)

☐ PDF on a CD

☐ Paper / Hard Copy

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
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