SOUTH COUNTY HEALTH

PATIENT NAME: _____

DOB: _____

MRN: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I authorize South County Health (SCH) to obtain/release/exchange my health information specific to the following date or time period: _____ or ☐ All episodes of care

   RECORDS FROM: ☐ South County Hospital ☐ South County Medical Group ☐ South County Home Health

2. ☐ **OBTAIN FROM:**

   Provider: _____

   Address: _____

   _____

   Phone: _____

   Fax: _____

   ☐ **RELEASE TO:**

   _____

   Address: _____

   _____

   Phone: _____

   Fax: _____

3. Patients may elect to have copies of their medical record provided electronically.
   Please check ☐ to indicate your wish to have your medical records provided in an electronic format.
   Email address: _____

4. Purpose for which disclosure is to be made: _____

5. Information to be disclosed/exchanged:

   ☐ Discharge Summary
   ☐ History and Physical Exam
   ☐ Consultations
   ☐ Medications
   ☐ Other: _____
   ☐ Operative Report
   ☐ Pathology
   ☐ Emergency Dept. Report
   ☐ Office Notes
   ☐ Progress Notes
   ☐ Laboratory Report
   ☐ Radiology Report
   ☐ PRINT ☐ ELECTRONIC ☐ BOTH
   EXAM: _____

   I understand this may include health information relating to *(check if applicable)*:

   ☐ HIV (Human Immunodeficiency Virus) infection
   ☐ Treatment for alcohol and/or drug abuse
   ☐ Behavioral Health
   ☐ Genetic Testing

6. I understand that if the person(s) or entity(s) that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release SCH, its employees and contractors from all liability arising from this disclosure of my health information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

7. I understand that SCH may receive compensation for the authorized use/disclosure of this information.

PLEASE CONTINUE TO PAGE 2 AND COMPLETE THE AUTHORIZATION.

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PAGE 2: AUTHORIZATION

8. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the department that provided the information, knowing that previously disclosed information would not be subject to my revoke request.
9. 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.
10. I understand that this authorization shall be retained as a part of my protected health information in accordance with applicable SCH policy. I have received a copy of this authorization.
11. This authorization expires on _____ or ninety days from the date this authorization was signed. I further understand that I may revoke this authorization in writing at anytime except to the extent that action has been taken on it.

Patient or Legal Representative: _____ Date: _____

Witness Signature: _____ Date: _____

Relationship to Patient if Signature Not Patient: _____

☐ Photo ID verified By: _____ Receipt Date/Time _____ / _____

MAIL, FAX, OR EMAIL THE COMPLETED FORM TO:

South County Health
Health Information Management
100 Kenyon Avenue
Wakefield, RI 02879

FAX: 401-789-5571
EMAIL: medrecrelease@southcountyhealth.org