Authorization for Release of Health Information

*This form applies **only** to the release and disclosure of your health information.*
It is not a consent for treatment and is not intended for any other purposes.

By signing this form, I authorize SouthCoast Health to release or disclose the protected health information described below to:

NAME: ______________________________
ADDRESS: ______________________________
____
____

FAX: ____________________ PHONE: ____________________ Patient Initial ________

(If information is to be faxed, these numbers must be provided by patient.)

Purpose of disclosure: patient request, employment, life or disability insurance, other ____________________
This information should be **Certified**: YES NO unless otherwise **Revoked**: YES NO

NOTE: This authorization expires upon fulfillment of request. Information will not be resent without another signed authorization OR authorization expires one (1) year from date of signature.

Patient's Name (Printed) ______________________________

SS# ____________________ DOB: ____________________

I authorize the following information to be sent to the address above:

___ Copies of all records for the period (including billing records) ______ /______ /______ to ______ /______ /______
Month Day Year Month Day Year

___ Copies of the information described below from ______ /______ /______ to ______ /______ /______

___ History & Physical Examination ___ Lab Reports ___ Billing Records

___ X-ray Reports ___ Other (Please Specify) ____________________

I understand that this information is of a personal medical nature and may include any history of or references to acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should ***not*** be released, even if occurring during dates above -

Special requirements: certified mail, extended expiration date, and the like - ____________________
____
______________________________ Patient Initial ________

I have been provided a copy of SouthCoast Health's *Notice of Privacy Practices* and am aware that there are charges for copies of records made pursuant to this authorization. I have discussed any concerns I may have about the release or disclosure of my health information with SouthCoast Health's Privacy Officer or other appropriate office personnel.

I understand that SouthCoast Health assumes no responsibility for the subsequent use/misuse by others of my health information which was disclosed under this authorization. I release SouthCoast Health from all legal liability that may arise from release of my information under this authorization.

Signature of Patient/Authorized Representative ____________________ **Date** __________

If authorized representative, include documentation of nature of representation: ____________________

My legal relationship to the patient is: ____________________

Signed ______________________________

☐ Check here if you would like records on electronic copied disk.

The patient or their representative may revoke this authorization by notifying in writing SouthCoast Health's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"). Federal law also requires a statement that there is the potential that the protected health information released under this authorization may be subject to re-disclosure by the recipient. Any such re-disclosure is beyond the control of SouthCoast Health.