SouthCoastHEALTH

Authorization for Request of Health Information

*This form applies **only** to the release and disclosure of your health information **from** another medical provider. It is not intended for any other purposes.*

By signing this form, I authorize SouthCoast Health to OBTAIN protected health information needed for my treatment from:

PROVIDER NAME: _____

ADDRESS: _____

_____

_____

NOTE: This authorization expires upon fulfillment of request.

I authorize copies of my medical information to be sent to SouthCoast Health to the attention of Dr. _____at:

ADDRESS: _____

_____

_____

I understand that this information 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.

_____ _____

Print Patient's Name **Patient's Signature**

Date _____ **SS#** _____ **DOB:** _____

If the signature above is not that of the patient, I am acting for the patient because

_____

My relationship to the patient is: _____

Signed _____