SOUTH COUNTY HEALTH
100 Kenyon Avenue | Wakefield, RI 02879
P: 401-788-1477 | F: 401-789-5571
medrecrelease@southcountyhealth.org

Patient Name: ______________________________

Date of Birth ____/____/____ 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: ______________________________

RECORDS FROM:

❑ **South County Hospital**

❑ **South County Medical Group**

Physician: ______________________________

2. **OBTAIN FROM:** ______________________________
____
____
____
Phone: ______________________________

RELEASE TO: ______________________________
____
____
____
Phone: ______________________________

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
   - ❑ Consultations
   - ❑ Medications
   - ❑ Operative Report
   - ❑ Pathology
   - ❑ Emergency Department
   - ❑ Office Notes
   - ❑ Progress Notes
   - ❑ Laboratory
   - ❑ Radiology
     _ Print _ CD _ Both
     Please specify exam ____________
   - ❑ Other: ______________________________

   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.

**** Please continue to the second side and complete the authorization. ****

SOUTH COUNTY
HEALTH

100 Kenyon Avenue | Wakefield, RI 02879
P: 401-788-1477 | F: 401-789-5571
medrecrelease@southcountyhealth.org

Patient Name: ______________________________

Date of Birth: ____/____/______ MRN: __________

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PAGE 2: AUTHORIZATION

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

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 SCHHS 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
E-mail: medrecrelease@southcountyhealth.org