South Shore
skin center

CHARTFAST

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Please complete, sign and return this form to: South Shore Skin Center, Medical Records Department, 1 Scobee Circle, Unit 3, Plymouth, MA 02360 ***Or*** submit via fax to 508-746-9265. Contact us at 508-747-0711 ext. 5166 with questions.

Patient Name:

____

Last First MI

Address:

____

Street (include Apt #, if applicable)

____

City State Zip Code

Birth Date ______/______/_________ **HomePhone** #: ___________________________**Cellphone** #______________________________

I hereby authorize South Shore Skin Center to release my protected health information to:

☐ Mail to: ☐ Fax to: ☐ Hold for pick up by:

Name: ____

Address:____

Fax phone number: ___________________________________Office phone number (if known):__________________________________

PURPOSE OF DISCLOSURE (Please check one)

☐Myself☐ Inspection ☐ Changing physicians ☐ Consultation ☐ School ☐ Legal ☐ Other (specify) ______________

INFORMATION TO BE RELEASED (Please be specific and enter date of service if known):

☐ Entire medical record______________________, excluding ________________________________
☐ Medical Record Abstract (e.g. H&P, Operative Rpt, labs, x-rays, pathology)
☐ Clinic notes____ ☐ Pathology Reports _____________________________
☐ Operative Reports____________________________________ ☐ Photographs __________________________________
☐ Medication Records___________________________________ Itemized Bill ____________________________________
☐ Other (specify content)____

I request the release of the specifically protected or privileged categories of information that I have initialed below:

_______**HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
_______**Alcohol & Drug Abuse Records**Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2).
_______**Psychiatric Records or Information**
_______**Sexually Transmitted Diseases (STDS)**

I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Practice Administrator. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and South Shore Skin Center will not condition my treatment, payment, health plan enrollment, or eligibility for benefits on my providing authorization for the requested use or disclosure. *I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient. I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be redisclosed by the recipient and may no longer be protected by federal or state law.* I understand that I may inspect or copy the information to be disclosed, for a reasonable charge.

If I fail to specify an expiration date or event, and unless otherwise revoked, this authorization will expire six months from the date of the signature listed below. I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of my condition to those persons or agencies listed above.

Signature of Patient (18 years or older)____**Date**__________________

Signature of Legal Representative____Relationship to Patient: _________________Date______

This authorization expires as of:____

Please make a copy of this release for your records.

Revised 11/7/2011