South Shore Medical Center

Authorization to Release Medical Records

P.O. Box 9147, Norwell, MA 02061

Delivery Instructions

❒ Send via US Postal Service

❒ Pick up -- Name of person picking up records
(If other than patient or authorized representative)

_____

❑ Norwell ❑ Kingston ❑ Weymouth Woods

Please note that record requests may be subject to a cost based fee.

MRN: _____
(Office use only)

Patient's Name: _____ Date of Birth: _____
(Please Print)

Address: _____ _____ _____
Street City State Zip Telephone No.

I hereby, authorize South Shore Medical Center to release protected health information, including copies of the medical record of the above-named patient, to the following person or facility:

_____
Name of Person or Facility

_____
Street City State Zip

Purpose of Release: ***Please allow 7-10 days to process your request.***
(You will be notified by the Medical Records Department if processing fees apply)

❑ Medical Care ❑ Legal
❑ Insurance ❑ Personal

❑ Leaving SSMC / Date effective: ____ /____/_____ Reason Leaving: _____
(Note: All appointments, orders and referrals after the transfer date will be cancelled)

Information to be released: ***(Requests for Radiology & Billing information must be made directly to that Department.)***

Dates of Treatment to be Released: _____ to _____ ❑ **Abstract** (med. & problem list, 2 yrs notes, 5 yrs all tests)

❑ Immunization Record ❑ Laboratory Result ❑ X-ray (Reports Only) ❑ Complete Record

❑ Office Notes: _____ ❑ Other: _____
Specify clinician(s)

Release of Information Requiring Specific Consent: The following categories of information may be in your medical record and ***WILL NOT*** be released unless you indicate your specific authorization by initialing each appropriate category.

____ Abortion
____ Alcohol/Drug Abuse
_____ Genetic Testing
_____ Behavioral/Mental Health
_____ Domestic Violence
_____ Sexually Transmitted Diseases
_____ HIV/AIDS Results/Treatment
_____ Rape/Sexual Assault

STOP ***Please confirm that you have initialed all categories that may be contained in your record to authorize their specific release.***

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at SSMC unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required.
- I may revoke this authorization at any time by submitting a written notice of revocation to SSMC at the address listed below. The revocation will be effective upon SSMC's receipt of my written notice, except that it will not have any effect on any action already taken by SSMC in reliance on this authorization.
- Once SSMC has disclosed my health information to the recipient, SSMC cannot guarantee that the recipient will not redisclose my health information to a third party.
- This authorization will automatically expire 90 days from the date set forth below unless otherwise specified: _____

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to patient or authority to act for patient

****Copy of signed supporting legal documentation showing your status as authorized representative must accompany this request.***

THIS AUTHORIZATION MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL NOT BE PROCESSED

South Shore
Medical Center

Medical Record Processing Fee Information

Dear Patient:

Thank you for completing the South Shore Medical Center Medical Record Authorization to Release Form.

To assist you, it is helpful to know that most of the providers find a two year "abstract" of the medical records is sufficient to assume care of a new patient. An abstract includes:

- Problem List
- Medication List
- Two (2) Years Progress Notes
- Two (2) Years Labs Reports
- Five (5) Years X-Ray Reports
- Five (5) Years EKG's
- Five (5) Years Diagnostics

However, fulfilling any request for medical records is a time-consuming and costly process which involves:

- Retrieving and re-filing the paper chart (as applicable)
- Locating, copying and printing relevant documents
- Supplies such as paper, envelopes, toner, equipment usage
- Postage

To offset the rising costs associated with producing medical record copies, it has become necessary to ask for payment **before** each request can be processed.

South Shore Medical Center charges a cost-based fee for a medical record at the allowable state rates and will not exceed a fee of $25.00. For more information please visit the Massachusetts General Laws website.

GENERAL LAWS OF MASSACHUSETTS – PART I.
ADMINISTRATION OF THE GOVERNMENT – TITLE XVI. – PUBLIC HEALTH

CHAPTER 111. PUBLIC HEALTH – HOSPITALS
Chapter 111: Section 70 Records of hospitals or clinics; custody; inspection; copies; fees

The fees for medical records can be remitted by cash, check made payable to SSMC or credit card. Your request will be fulfilled upon payment.

Should you have any questions, please feel free to contact the Medical Records Department in Norwell at 781-261-4417.

Sincerely,

South Shore Medical Records Department

Rev.: 04/08/2016 JAEK, 09/12/2016 KJR