75 Washington Street, Norwell, MA 02061
5 Tarkiln Road, Kingston, MA 02364-1250
90 Libbey Parkway, Weymouth, MA, 02189
51 Performance Drive, Weymouth, MA 02189

Delivery Instructions

❐ Send via US Postal Service

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

____

❑ Norwell ❑ Kingston ❑ Libbey Pkwy ❑ Weymouth Woods

Authorization to Release Medical Records

MRN: ______________________________
(office use only)

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

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 ___________ ❑ Laboratory Result ❑ X-ray (Reports Only)

❑ Office Notes: ____________________________ ❑ Immunization Record ❑ Complete Record
Specify Clinician(s)

❑ Abstract ❑ Other: ____

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 _____ Behavioral/Mental Health _____ HIV/AIDS Results/Treatment

____ Alcohol/Drug Abuse _____ Domestic Violence _____ Rape/Sexual Assault

_____ Genetic Testing _____ Sexually Transmitted Diseases

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

I understand that:

- 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

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