South Shore Medical Center

Authorization for Verbal Disclosure of Health Information

P.O. Box 9147, Norwell, MA 02061 / Fax: 781-878-5044

Patient Information

Important: Please initial each section as applicable

Patient Name: _____ **Date of Birth:** _____
(Please Print)

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Preferred Phone Number** _____

Verbal Disclosures

I Authorize staff of South Shore Medical Center (SSMC) to speak with the following individual(s) regarding my current care and treatment:

Name: _____ Name: _____

Phone # _____ Phone# _____

Relationship to patient: _____ Relationship to patient: _____

❑ No restrictions to verbal disclosures. **Patient's Initials**: _____

❑ Verbal Disclosures restricted to dates of service and/or diagnoses as follows: _____

Patient Initials: _____

I authorize SSMC to verbally disclose my protected health information (PHI) to the individual(s) noted above. I understand this authorization encompasses all PHI including, but not limited to sensitive information such as: HIV/AIDS, abortion, behavioral/mental health, alcohol/drug abuse treatment, rape/sexual assault, sexually transmitted disease, domestic violence and genetic testing unless otherwise excluded by initialing the statement below.

I do **NOT** authorize the disclosure of sensitive information as noted above. _____
Patient Initials

Additional Authorizations Related to Verbal Disclosures

Voice Messages Regarding Treatment or Test Results

I Authorize staff of SSMC to leave a detailed message on my preferred phone regarding my clinical treatment and/or non-sensitive test results with or without restrictions as indicated below:

❑ No restrictions to information included in voice messages. **Patient Initials**: _____

❑ Restrictions to information included in voice messages as follows: _____ **Patient Initials**: _____

Voice Messages for Prescriptions

I Authorize staff of SSMC to leave a message on my preferred phone indicating my prescription(s) is ready for pick-up. I understand the name(s) of the prescription(s) will not be disclosed in the message.

Additional Instructions for Messages for Prescription Pick Up: _____**Patient's Initials:** _____

I understand:

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at an SSMC Facility 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. The revocation will be effective upon 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.

Select Authorization Timeframe:

❑ This authorization will remain valid as long as I am a patient of South Shore Medical Center.

❑ This authorization will expire on: _____
(Specify expiration date)

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions. By my signature below, I hereby, knowingly and voluntarily, authorize SSMC to verbally disclose my health information or fulfill specific instructions in the manner described above.

Patient Signature: _____ *Date:* _____

Personal Representative Signature: _____ *Relationship to patient:* _____

Form ID: AVD-1 4/8/13 – Revised 12/4/14