

Authorization for Verbal Disclosures and/or Specific Instructions for Health Information

Patient Name: _____ (Please Print)	Date of Birth: _____
Address: _____	City: _____
State: _____ Zip: _____	Preferred Phone Number: _____

Complete for VERBAL DISCLOSURES	Complete for VOICE MESSAGES REGARDING TREATMENT OR TEST RESULTS
<p>I hereby authorize staff of South Shore Medical Center to speak with the following individual(s) regarding my care and treatment at SSMC.</p> <p>Name: _____ Please Print</p> <p>Phone # _____ Relationship: _____</p> <p>Name: _____ Please Print</p> <p>Phone # _____ Relationship: _____</p> <p><input type="checkbox"/> No restrictions to verbal disclosures</p> <p><input type="checkbox"/> Verbal Disclosures restricted to dates of service and/or diagnoses as follows: _____</p>	<p>I authorize staff of South Shore Medical Center to leave a detailed message on my preferred phone regarding my clinical treatment and/or test results with or without restrictions as indicated below.</p> <p><input type="checkbox"/> No restrictions to information included in voice Messages</p> <p><input type="checkbox"/> Restrictions to information included in voice messages as follows: _____ _____</p> <p style="text-align: right;">_____ (patient initials)</p>
Complete for ADDITIONAL INSTRUCTIONS or RESTRICTIONS	VOICE MESSAGES FOR PRESCRIPTIONS
<p>NOTE: SSMC will make every reasonable effort to comply with your specific instructions; however, certain circumstances may impede such compliance.</p> <p>_____ _____</p>	<p>I authorize staff of South Shore Medical Center 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.</p> <p style="text-align: right;">_____ (patient initials)</p>

I understand:

- 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 South Shore Medical Center at the address listed above. 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. Such third party may not be required to abide by this Authorization or applicable Federal and State law governing the use and disclosure of my health information.

Select Authorization Timeframe:

- This authorization will remain valid as long as I am a patient at 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 South Shore Medical Center to verbally disclose my health information or fulfill specific instructions in the manner described above.

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Relationship to patient: _____