Request for Access and Authorization for
Use and/or Disclosure of Protected Health Information

Please Print:

Patient's Legal Name: ______________________ Date of Birth: ______________

Patient Address: ______________________ Phone Number: ______________

City: ______________________ State: __________ Zip: __________

I authorize the following SouthCoast Health office,

Office Name: ______________________ Phone: ______________

Address: ______________________ Fax: ______________

City: ______________________ State: __________ Zip: __________

To ☐ Disclose my medical records to, OR ☐ Obtain my medical records from:

Office Name: ______________________ Phone: ______________

Address: ______________________ Fax: ______________

City: ______________________ State: __________ Zip: __________

Send Records Via:

☐ Email address for record delivery: ______________________

☐ Fax records to physician. FAX #: ______________________

☐ Records on paper

Purpose of request: ☐ Personal ☐ Treatment (continued care) ☐ Other: ______________

Please furnish the following information specified for the following visit dates: ______________

Check all appropriate boxes below. If you fail to specify, a 1 year abstract will be provided.

☐ Office Notes ☐ Laboratory Results ☐ EKG ☐ Radiology Results

☐ Complete Record ☐ Other (please describe):______________________

I understand that the protected health information specified below may include mental health substance abuse (drugs, alcohol), HIV/AIDS status information, diagnostic and treatment records. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature: ______________________Date: ______________

Patient or Authorized Person: ☐ Parent ☐ Legal Guardian ☐ Executor ☐ Power of Attorney

Witness: ______________________Date: ______________