SOUTH SHORE HOSPITAL

MIDWEST ROI
Secure health record fulfillment

Authorization to Request Release of Health Information

Patient Information:	Reason for Request:
Name: _____ Date of Birth: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____	☐ Personal Copy ☐ Continuity of Care ☐ Legal/Insurance ☐ Other (please specify) _____ Send Records By: ☐Mail ☐Fax ☐CD ☐Other: _____
Records to be Provided from: (Enter Your Doctors/Office information) Facility/Provider: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	Send Records To: Person/Facility/Agency: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ Email: _____

Information to be Disclosed: Dates of Service requested: ____/____/____ To ____/____/____

☐ Emergency Room Record ☐ Laboratory Report(s) ☐ Radiology Report(s) ☐ Immunization Record ☐ Itemized Billing Records

☐ Office Notes ☐ Abstract/ Summary ☐ Complete Record ☐ Prenatal Records

☐ Test Result (s) of: _____

☐ Other: _____

I understand that the information contained in my health record may include information relating to sexually transmitted diseases, acquired or mental health services, and treatment of alcohol and/or drug abuse. I authorize the release of all such items EXCEPT for those which I have marked below. By checking the boxes next to these items, I understand that the following information will **NOT** be released.

☐ Alcohol or Substance Abuse Records ☐ HIV and/or STD Testing and Results ☐ Mental Health Records ☐ Genetic Records

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations and I was notified in advance of said fees. By submitting this request, I am accepting all associated fees and authorizing the provider/Midwest ROI to process my request for records. An invoice will be sent to me once the request has been processed.
- I understand that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by other pares besides the person to whom it is addressed. The provider/Midwest ROI has notified me of the risks and will not be held liable if I choose to have my records sent by email.
- I have the right to revoke this authorization at any me. Revocation must be made in wring and presented or mailed to the Health Information Management Department at the facility at which this request is received. Revocation will not apply to information that has already been disclosed in response to this authorization.
- I have a right to inspect and copy the health information disclosed as a result of the delivery of this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
- Any disclosure of information carries with it the potential for re-disclosure, and the information may no longer be protected by federal confidentiality rules.
- If any, Consequences of Failure to consent: _____

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Relationship to Patient (if applicable) Date

_____ _____
Witness Signature required to release Mental Health Records Date