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

SouthCoastHEALTH

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: _____

Dear Patient:

Thank you for contacting **SouthCoast Health** Medical Records Department. To better serve you with your request for medical records, **SouthCoast Health** has partnered with Sharecare.

Sharecare will fulfill your request for records in a safe, secure, and timely manner.

To receive a copy of your records, you will need to complete and return the attached Authorization form. Please make sure you have *specific* instructions included as to **what** records you are requesting and **where** you are requesting records to be sent. You also have a choice of **how** you would like to have your records delivered. For records to be delivered directly to you, please choose mail or email. For records to be delivered to another doctor, please choose fax or mail. Please select only one option. *The fax delivery option may only be used for records going to a doctor.* ***Please return the completed Authorization form to your SouthCoast Health office.***

For Records being sent to another Health Care Provider

Please provide as much contact information for your other Doctor, including the address, phone & fax.

You can contact a Sharecare Health Data Services representative at any time by calling:

858-244-1811

Thank you,

Medical Records Supervisor
SouthCoast Health