South Shore
OBSTETRICS & GYNECOLOGY
Women's Health Care

EMERGENCY CONTACT/RELEASE OF INFORMATION

ID#_____
Staff Initials _____

Patient Name	Date of Birth

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of South Shore Women's Health Care to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **DO NOT** authorize South Shore Women's Health Care to release any or all information concerning my medical care to any individual ***except during an emergency situation*** as mentioned above.

Emergency Contact Name	Relationship	Phone Number(s)

_____ I **DO** authorize South Shore Women's Health Care to verbally release *any or all information* concerning my medical care to the following individuals:

Name	Relationship	Phone Number

Patient Information: I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

Patient Signature: _____ **Date:** _____