**Authorization For The Use And / Or Disclosure Of Protected Health Information**

**This Notice describes how Medical Information about You may be used and disclosed and how you can gain access to this information. Please review it carefully.**

I authorize the use and/or disclosure of my “Protected Health Information” as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization: **Medical and Health Information**

2. I authorize **South Shore Primary and Urgent Care, LLC and individuals that work for and / or with SSPUC** to make the authorized use and/or disclosure of my Protected Health Information

3. I authorize the following persons (or class of persons) to receive my Protected Health Information: services required for rendition of my health care; for example assistive services such as home health care agencies, diagnostic services including laboratories, radiology suites, services required for payment; health insurer (if and when warranted to cover non-physician services), or other company that arranges or pays the cost of some or all of your health care, health care operations; such as activities that improve the quality and cost effectiveness of the care that we provide.

4. I understand that, if my Protected Health Information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (*delivered to the practice at address below*). I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

I certified that I have received a copy of the authorization.

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|  |  |
| Signature | Date |
|  |  |
| Name |  |
|  |  |
| Name of Personal Representative | Relationship to Patient |

Uses and Disclosures without Your Consent or Your Authorization

1. We may use or disclose your PHI for Treatment, Payment and our health care operations without Your Consent or Your authorization under the following circumstances:
   1. When you require emergency treatment
   2. When we are required by law to treat you and we attempt to and are unable to obtain your consent
2. Public Health Activities: We may disclose Protected Health Information for public health activities and purposes:
   1. to report information to public health authorities for the purpose of preventing or controlling disease, injury or disability
   2. to report abuse of persons/neglect to public health authorities and other government authorities authorized to receive such information
   3. to report information about products to the U.S. Food and Drug Administration
   4. to alert person who may have been exposed to communicable disease and may otherwise be at risk of contracting or spreading disease or condition
   5. to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance
3. Law Enforcement Officials: We may disclose PHI to police or other law enforcement officials as required by law or in compliance with a court order
4. Judicial and Administrative Proceedings: We may disclose Protected Health Information in the course of a judicial or administrative proceedings in response to a legal order or other lawful processes
5. Health or Safety: We may use or disclose Protected Health Information to prevent or lessen a serious and imminent threat to a person’s or the public’s health and safety.
6. Decedents: We may disclose Protected Health Information to a coroner or medical examiner as authorized by law.
7. Specialized Government Functions: We may use and disclose Protected Health Information units of the government with special functions such as the U.S. military or the U.S. Department of State under certain circumstances.
8. Victims of Abuse, Neglect or Domestic Violence: We may disclose Protected Health Information without your consent or your authorization if we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency, including social service or protective services agency, authorized by law to receive such reports of abuse, neglect or domestic violence.
9. Workers’ Compensation: We may disclose Protected Health Information as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs

**Effective Date and Duration of This Notice**

1. Effective Date. This Notice effective on Feb 23, 2016
2. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Heath Information that we maintain, including any information created or received prior to issuing the new notice. You may obtain any new notice by contacting our Office.

You may contact our office at:

South Shore Primary and Urgent Care, LLC

20 East Street,

Hanover, MA 02339

Telephone Number: (781)561-0460

I certified that I have received a copy of the authorization.

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|  |  |
| Signature | Date |
|  |  |
| Name |  |
|  |  |
| Name of Personal Representative | Relationship to Patient |