Shields® HEALTH

CONNECT PATIENT PORTAL

NOW AVAILABLE :

Online Access to Your Imaging Medical Records

Shields Connect provides immediate, online access to your imaging medical records through our secure, password-protected patient portal.

epatient.shields.com

It's *easy* – just scan the QR code and request an account.

MRN (office use only): _____

Authorization for Disclosure of Medical Record Information

Instructions:

Please complete, sign and return this form to Medical Records:

1. Fax: 855-600-5364
2. E-mail: MedicalRecords@shields.com
3. Mail to: Shields Health Care Group, Inc.
   55 Christy Dr., Brockton, MA 02301
   Attn: Medical Records

You are now able to access your medical records and bills electronically. Please refer to page two for instructions.

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____
Street City/Town State Zip Code

I hereby authorize the Provider to release a copy of my medical records specified below to the following person (the "Recipient"):

Recipient's Name: _____

Recipient's Address: _____

Recipient's Email Address: _____ Recipient's Phone Number: _____

Date(s) of Service: _____

The medical records to be disclosed to the Recipient are: (please check those that apply)

☐ Medical Report(s) ☐ Images

Applicable category of medical records: (please check one)

☐ Imaging (MRI, PET, CT, Ultrasound, Mammo) ☐ Ambulatory Surgical Care ☐ Urgent Care

If you are requesting that your medical records be sent to a person other than yourself, please state the purpose of the disclosure. If you do not wish to state the specific reason, simply write, "At my request**."**

Purpose of disclosure: _____

I am aware that the medical records I am authorizing be disclosed pursuant to this Authorization may contain the following highly sensitive information: alcohol/drug use, abuse and/or treatment, treatment for mental illness and/or social services communications, history of venereal or other communicable disease(s), treatment or testing for HIV/AIDS. I request that the following medical records be excluded from this disclosure: _____

_____ _____ _____

Signature of Patient/Parent/Legal Representative* **Printed Name** **Date**

If signing as a legal representative, also provide appropriate paperwork to support status.

For questions please contact the Medical Records Department @ 800-258-4674, Option 3

Term: This Authorization will remain in effect until the Provider fulfills this request. **Revocation:** I understand that I may revoke this Authorization at any time by submitting a written request to the Provider C/o Shields Health Care Group, Inc. 55 Christy Dr., Brockton, MA 02301, Attn: Medical Records. I understand that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before it received my written notice of revocation. **Effect on Treatment:** I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment by the Provider. **Potential for Redisclosure:** I understand that the person receiving my medical records may not be required to comply with federal and state privacy laws, and that my medical records may no longer be protected by the applicable state and federal law once disclosed by the Provider. **Access**: I understand that in certain circumstances the Provider has the right to deny me access to all or portions of my medical records and must notify me in writing of any such denials.