Rhode Island Hospital
A Lifespan Partner

Health Information Services
593 Eddy Street
Providence, RI 02903
Tel 401-444-4040 • Fax 401-444-7936

AUTHORIZATION FOR USE OF PROTECTED HEALTH CARE INFORMATION

Patient Name _____ Phone Number _____

Date of Birth _____ Medical Record # (or SS#) _____

Address _____

1. I authorize Rhode Island Hospital to disclose my health information specific to the following date or time period:

   _____

2. Name & Address of individual or entity authorized to receive my health information:

   Name _____

   Street_____City/Town/State/Zip Code_____

3. Purpose for which disclosure is to be made:

   _____

4. Information to be disclosed (check all applicable):

☐ Emergency Dept. Record	☐ History & Physical Exam	☐ Pathology Report	☐ Laboratory Report
☐ Entire Medical Record	☐ Consultation	☐ Discharge Summary	☐ Radiology Report
☐ Abstract	☐ Operative Report	☐ EKG	☐ Other _____

5. Please check one: I hereby
   ☐ **Consent** ☐ **Refuse**
   to the release of confidential information concerning: Mental health, alcohol and/or drug use, sexual abuse, venereal disease, AIDS or HIV test results

6. I understand that my records are protected under the federal privacy laws and regulations and under the General laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

7. I understand that if the person(s) or entity(ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Rhode Island Hospital, its employees and my physicians from all liability arising from this disclosure of my health information.

8. It is my understanding that this authorization will expire 90 days from the date signed below. I understand that I may revoke this authorization by notifying Rhode Island Hospital in writing. I understand that any previously disclosed information would not be subject to my revocation request.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits, unless otherwise described in the space provided here

   _____

THERE IS A PROCESSING FEE AND COPYING COST.
This form must be completed in full before signing.

_____ _____
Signature of Patient or Patient's Legal Representative **Date** **Print Patient's Name**

_____ _____
Print Name of Legal Representative (if applicable) **Relationship to Patient**

Original - Chart Copy - Patient