10136

Care New England

FOR INPATIENTS: AFFIX PATIENT LABEL OR WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

10136 (5-2021)

AUTHORIZATION TO RELEASE HEALTH INFORMATION

1. Patient name: _____ _____ ("Patient") Date of Birth: _____ Telephone: _____

   Address: _____ (Street) _____ (City) _____ (State) _____ (Zip) Med. Rec. #: _____

2. The undersigned hereby authorizes the following CNE Provider ___ _____ (Insert Hospital/Facility/Physician name) (the **"Provider"**)

   Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

   Telephone: _____ _____ Fax: _____ _____

☐ to release/disclose to the individual and/or entity named in Section 3 **("Recipient")**

AND/OR

☐ to request/receive from the individual and/or entity named in Section 3 **("Disclosing Party")** the protected health information **("Health Information")** specified in Section 4

3. Recipient or Disclosing Party. ___ East Providence Police Department- Detective Division (Insert Individual/Entity Name)

   Telephone: 4014357600 _____ Fax Number (if Health Information is to be faxed): (401) 563-8973

   Address: 750 Waterman Ave East Providence RI 02914 (Street) (City) (State) (Zip)

4. Please check one or more types of Health Information to be released/requested:

___ Allergies	___ Laboratory Results	___ Operative Report
___ Immunization Records	___ X-Ray/Imaging Results	___ Psychiatric Exam
___ Emergency Dept. Records**	___ History & Physical	___ Psychological Tests
___ Registration Record	___ Progress Notes	___ Treatment Plan(s)
___ Discharge Summary	___ Consultation Reports	___ Entire Record

OTHER (Please specify): _____

An authorization for Emergency Department Records may include any of the above listed Health Information records.

5. Time frame for which the Health Information authorized in Section 4 above should be released/requested:
   For the period from _____ (insert start date) through _____ (insert end date);
   OR *ALL DATES OF TREATMENT* _____ (Please initial)

6. The undersigned acknowledges, agrees, and understands that unless specifically limited below, any Health Information released may include mental health treatment information, alcohol and substance abuse treatment information, STDs and/or HIV/AIDS-related information.
   DO NOT RELEASE THE FOLLOWING HEALTH INFORMATION (Please specify): _____

7. This authorization is being requested by the undersigned for the following purpose(s) (initial all that apply)
   ___ Medical Care ___ Legal ___ Insurance ___ Personal
   Other (Please describe): _____

8. The undersigned acknowledges and understands each of the following:
   - authorizing the release of the Patient's Health Information is voluntary;
   - refusal to sign this authorization does not affect the Patient's treatment, payment of claims, health plan enrollment or eligibility for benefits;
   - this authorization may be revoked at any time upon written request to the Provider's privacy officer or health information department except to the extent that release of Patient's Health Information has already occurred in reliance on this authorization;
   - unless previously revoked, this authorization will automatically expire TWELVE (12) months from the date of signature below unless a shorter timeframe specified here _____ (enter date authorization will expire);
   - ***any information released to the Recipient may be re-disclosed and may no longer be protected by federal or state privacy and or confidentiality laws.***

THE UNDERSIGNED (1) HAS READ AND UNDERSTANDS THIS AUTHORIZATION; (2) HAS HAD ANY QUESTIONS WITH RESPECT TO THIS AUTHORIZATION EXPLAINED TO HIS/HER SATISFACTION; (3) IS AUTHORIZED TO SIGN THIS AUTHORIZATION INDIVIDUALLY AS THE PATIENT OR AS THE PATIENT'S LEGAL REPRESENTATIVE; AND (4) HEREBY EXPRESSLY AND VOLUNTARILY AUTHORIZES THE RELEASE/ REQUEST OF THE PATIENT'S HEALTH INFORMATION AS SPECIFIED ABOVE.

_____ Signature of Patient or Legal Representative of Patient — _____ Date/Time

_____ PRINT name of Patient or Legal Representative of Patient — _____ Relationship to Patient or Authority to Act for Patient

THIS AUTHORIZATION SHALL BE INVALID UNLESS ALL APPLICABLE SECTIONS ARE COMPLETE