



**HEALTH INFORMATION SERVICES
AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED INFORMATION**

_____ **REQUEST COPIES OF MEDICAL RECORD**

_____ **REVIEW MEDICAL RECORD**

I do hereby authorize the following CharterCARE Health Partners affiliates entities (to include without limitation)

- | | |
|--|---|
| ☐ Roger Williams Medical Center | ☐ St. Joseph Health Services |
| ☐ Roger Williams Medical Associates | ☐ Our Lady of Fatima Ancillary Services |
| ☐ Elmhurst Extended Care Facility | ☐ Southern New England Rehabilitation Center |
| ☐ Elmhurst Health Associates | ☐ All |

to release my protected health information, including copies of my medical record of care to the following person(s) or persons at the location/facility listed below for the purpose(s) as indicated:

Patient Name: _____ **DOB:** _____
(Last) (First) (M.I.)

Patient Address: _____

Patient Telephone (for contact): () _____ work /home / cell

Email address: _____

Recipient

East Providence Police Department

Name

750 Waterman Ave

Address
East Providence RI 02914

City, State, Zip Code

Purpose (check the appropriate box)

- ☐ Medical Care
☐ Legal Matter
☐ Insurance
☐ Personal

☐ Other (please specify) *
* _____

Concerning my treatment for the period of: _____

PROTECTED HEALTH INFORMATION TO BE RELEASED (Please check the appropriate box(s) and provide dates):

- | | | |
|--|--|--|
| ☐ Discharge Summary (dates) _____ | ☐ Pathology Reports (dates) _____ | |
| ☐ Operative Reports (dates) _____ | ☐ Emergency Room (dates) _____ | |
| ☐ Outpatient Test Results (dates) _____ | ☐ Lab Reports (dates) _____ | |
| ☐ X-Rays/Scan Reports (dates) _____ | ☐ Other (please specify) _____ | |
| ☐ Reports | ☐ Films | ☐ Billing _____ |
| ☐ Medical Record Abstract (e.g. Discharge Summary, Consultations, History & Physical, Operative, Pathology, and Test Reports) | | |



Authorization for Release of
Specifically Protected Information

I request the release of the specific categories of information that I have **INITIALED** below:

_____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)

SPECIFY DATE(S): _____

_____ Records pertaining to Sexually-Transmitted Diseases

_____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2
(FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

_____ Other(s): Please List _____

Confidential Details of:

_____ Psychotherapy (from a Psychiatrist, Psychologist, or Psychiatric Clinical Nurse Specialist)
(cannot be authorized in conjunction with non psychotherapy authorization)

_____ Other professional services of a licensed psychologist

_____ Social Work Counseling/Therapy

_____ Domestic Violence Victims' Counseling

_____ Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management.
- Authorization may be withdrawn except for the following:
 - *To the extent that action has been taken in reliance on this statement
 - *If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization.
- If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer protected by this rule.
- I understand that even if I do not withdraw this consent that this statement shall expire in:
(please check one): _____ 3 months _____ 6 months _____ 12 months _____ Other
(if no time is indicated authorization will expire in one year)

I have carefully read and understand the above, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____ Relationship, if not patient _____

Print Name: _____ Witness: _____ Date: _____

Basis of Authority to act on behalf of the patient

TO BE COMPLETED BY OFFICE STAFF/FACILITY RELEASING INFORMATION:

Date ___/___/___ ID Verified: Y / N # Pages (if) Given to Patient _____ Initials: _____

Type of Delivery: Email _____ Mail _____ Other _____



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