BUTLER HOSPITAL
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ _____ Date of Birth: _____
(Please Print)

I authorize the use and/or disclosure of the above-named individual's health information as described in this authorization. I, therefore, authorize Butler Hospital, 345 Blackstone Boulevard, Providence, Rhode Island 02906 to:

☐ **Release to:** ☐ **Request from:**

Agency Name (If Applicable): _____

Name (First and Last): _____

Street Address: _____

City/State/Zip Code: _____

This authorization will have a duration of consent no longer than 90 days after the date of this form or for the duration of treatment should the duration of treatment be longer than 90 days. Information may be released by the following methods:

☐ Telephone/Verbal Phone #: _____
☐ Photocopies
☐ FAX Fax#: _____

Information to be released includes:

☐ Discharge Summary ☐ Psychiatric Exam ☐ Treatment Plan ☐ Progress Notes
☐ Psychological Test ☐ History and Physical ☐ Laboratory Data Including HIV
☐ Other (Please be specific): _____
For Dates of Service: _____

☐ **DO NOT RELEASE**: ☐ HIV Test ☐ *Other (Specific):* _____

The purposes of the request are described below (each purpose must be listed):

_____

☐ At the request of the individual for his/her own purposes.

I understand that the information in the health record may relate to treatment for alcohol and drug abuse and/or the results of diagnostic tests used to determine if the individual is infected by the human immunodeficiency virus (HIV). Unless I have indicated otherwise above, I specifically authorize the release of this information.

I understand that I have the right to revoke (cancel) this authorization at any time. I understand that to revoke this authorization, I must contact the Director of Medical Records at Butler Hospital and will be required to put my revocation (cancellation) in writing. I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released in response to this authorization. I also understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that signing this authorization is voluntary and that Butler Hospital will provide treatment and pursue payment for service regardless of whether I sign this authorization.

I understand that if I authorize Butler Hospital to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by Butler Hospital may no longer be protected by the federal rule on privacy of medical records.

_____ _____ _____ _____
Patient Signature or authorized Representative Date Witness Signature Date

_____ _____ Printed Name of Authorized Representative Relationship

☐ **Send Aftercare Information:**
Patient's Appointment Date: _____ Time: _____

- SSend