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

_____
Name
_____
_____
Address
_____
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) _____
- ☐ Operative Reports (dates) _____
- ☐ Outpatient Test Results (dates) _____
- ☐ X-Rays/Scan Reports (dates) _____
- ☐ Pathology Reports (dates) _____
- ☐ Emergency Room (dates) _____
- ☐ Lab 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_____