Rhode Island Hospital
A Lifespan Partner

Authorization for Use of Protected Health 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. Individual or entity authorized to receive my health information:

   _____

3 Purpose for which disclosure is to be made:

   _____

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

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

5. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under law. My check mark(s) below indicate(s) that I **do not** permit information of this type, if it exists, to be released. I understand that if I do not check the box, Rhode Island Hospital **will** release such information about me if it exists.

❑ HIV /AIDS infection	❑ Sexually transmitted diseases
❑ Mental Health	❑ Treatment for alcohol and/or drug abuse

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 receives the information is not a health care provider or health plan covered by federal privacy 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 in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, Rhode Island Hospital. 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_____

This form must be fully complete 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