Lifespan Medical Imaging
Rhode Island Hospital • The Miriam Hospital
Newport Hospital
Delivering health with care®

Authorization to Disclose Protected Health Information
(This form must be completed in full before signing)

PATIENT NAME: ____________________ PATIENT DOB: ____________________
ADDRESS: ____________________ PATIENT PHONE: ____________________
PATIENT MRN# ____________________ DATE REQUESTED ____________________

I hereby authorize Lifespan Medical Imaging to obtain from and/or release to:
Nuance PowerShare web account created for above patient

Email Address registered with Nuance Powershare: ____________________

Dates of treatment or time period any as requested by patient

Purpose for which disclosure is to be made: ☐ Coordination of Care ☒ Patient Request ☐ Legal
Other (please specify) ____________________

I do not want the following information disclosed: ☐ mental health ☐ alcohol/drug use/test ☐ sexual abuse ☐ sexually transmitted infections ☐ AIDS/HIV test results

TYPE OF RECORDS REQUESTED: ☐ REPORTS ☐ CD ☒ SPECIAL REQUESTS electronic DICOM images

METHOD OF RELEASE: ☐ PT PICK UP ☐ COURIER ☐ MAIL ☐ FED EX ☒ OTHER
Other online electronic share to patient's Nuance PowerShare web account connection with Lifespan Hospitals

- 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. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse.
- I understand that if the person(s) or entity (ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Lifespan, its employees and my physicians from all liability arising from this disclosure of my health information.
- It is my understanding that this authorization is for information we have at the time of your request, only for the information requested above and will expire one year from the date signed below. I understand that I may revoke this authorization by notifying Lifespan in writing. I understand that any previously disclosed information would not be subject to my revocation request.
- 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:

____________________ ____________________
Signature of Patient*, Legal Guardian, or Representative, Courier — Date/Time

____________________ ____________________
Print name of Patient, Legal Guardian or Representative, Courier — Date/Time

*Note concerning minors: For disclosures to persons/entities other than medical providers, the signature of a patient under 18 years who gave legal consent for testing, examination or treatment for reportable communicable disease (including HIV and venereal disease) or for alcohol and/or drug abuse treatment is required.