



Please Fax Medical Records Requests to 401-285-7245

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number (Last Four Digits Only): \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. I authorize \_\_\_\_\_ 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):

- Entire Medical Record  Pathology Report
- CT Scan  Operative Report
- Allergy Report  Vestibular Report
- History & Physical Examination  Audiology Report
- Laboratory Report  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, University Otolaryngology will release such information about me if it exists.

- HIV/AIDS infection  Mental Health
- Sexually Transmitted Diseases  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 RI, 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 University Otolaryngology, 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, University Otolaryngology. 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

**Please note there is a processing fee of \$1 per page for each of the first 50 pages and \$.50 for pages 51 and over. There is an additional \$20.00 fee for requests that need to be completed within 48 hours.**

This form must be fully complete before signing.

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient's Legal Representative

\_\_\_\_\_  
Relationship to Patient