University Otolaryngology

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) blew 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