Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide *all* information requested may invalidate this Authorization.

Name of Patient:_____

Date of Birth:_____ SSN: _____

Patient Address:_____

City: _____ State:_____ Zip:_____

Phone #:_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize_____

to release to: _____ **Covering the period** of healthcare from _____ to _____

Phone #:_____ Fax: _____

(Persons/Organizations authorized to *receive* the information) (Address - street, city, state, zip code and/or fax number)_____

The following information:

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received. - **OR**

☐ Only the following records or types of health information (including any dates):

☐ Discharge Summary ☐ Consultation(s) ☐ All pertinent Lab / X-rays / EKG

☐ History and Physical ☐ Operative Report ☐ Other: _____

☐ Rehab ☐ ER

b. I specifically authorize release of the following information (initial as appropriate):

_____ Mental health treatment information _____ STD

_____ HIV test results _____ Sexual Assault

_____ Alcohol/drug treatment information _____ Child Abuse/Neglect

_____ Outpatient psychotherapy notes

PURPOSE

Purpose of requested use or disclosure: ☐ patient request; **OR** ☐ other:

_____

_____

EXPIRATION

This authorization expires on: _____

PLEASE CONTINUE ON NEXT PAGE ⟶

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to:

Landmark Medical Center
115 Cass Avenue
Woonsocket, RI 02895

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by Rhode Island law and may no longer be protected by federal confidentiality law (HIPAA). However, Rhode Island law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Options of Electronic Format: According to HITECH section 13405(e) (1); 42 U.S.C. 17935 (e) (1), you may have your electronic medical records transmitted to you or another entity in electronic format. Please choose which type of format you would like the information to be delivered in and note the receiving entity may not accept records in electronic format: ☐ Burn to CD ☐ Paper

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____

(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient. Licensed Psychotherapist's approval for geropsychiatric patient:

_____

Witness: _____

PATIENT I.D.