Rhode Island Hospital
A Lifespan Partner

Rhode Island Hospital including Hasbro Children's Hospital
Health Information Services
593 Eddy Street
Providence, RI 02903
Tel: 401.444.4040 Fax: 401.444.7936

AUTHORIZATION FOR USE OF PROTECTED HEALTH CARE INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Phone _____

1. I authorize Rhode Island Hospital to (*check one*) ☐ Release To or ☐ Obtain From

2. _____
Name of Person / Place / Institution

_____
Street City/Town State Zip Code

3. Date(s) of treatment or time period _____

4. Purpose for which disclosure is to be made: _____

5. Information to be disclosed (check all applicable):
☐ Emergency Dept. Record ☐ Operative/Path Report ☐ Lab / X-ray Reports ☐ Clinic Report
☐ Abstract* ☐ Discharge Summary ☐ Entire Medical Record ☐ Other _____
*abstract includes: Facesheet, ED record, D/C Summary, Consult, Operative report, pathology report, test results, PT/OT/ST
☐ Discharge Instructions ☐ Cont. of Care Document (CCD) ☐ check here if you would like either of these sent electronically)
email address: _____

6. Please check one: I hereby ☐ Consent to ☐ Refuse
the release of confidential information concerning: mental health, alcohol and/or drug use, sexual abuse, venereal disease, AIDS or HIV test results

7. 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.

8. 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 Rhode Island Hospital / Hasbro Children's Hospital, its employees and my physicians from all liability arising from this disclosure of my health information.

9. It is my understanding that this authorization will expire 90 days from the date signed below. I understand that I may revoke this authorization by notifying Rhode Island Hospital / Hasbro Children's Hospital in writing. I understand that any previously disclosed information would not be subject to my revocation request.

10. 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 completed in full before signing. There may be a cost associated with this request.

_____ _____ _____
Signature of Patient, Parent or Legally Appointed Representative Date / Time Print Patient's Name

_____ _____
Print name of Parent or Legally Appointed Representative (if applicable) Relationship to Patient