

AUTHORIZATION FOR USE OF PROTECTED HEALTH CARE INFORMATION

Patient Name **Fred Long** Date of Birth **12/13/14**

Address **123 Main Street Hyde Park, Atlantis 01234** Phone **(123)456-7890**

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

- 2 **The Office of the President of the United States**

Name of Person / Place / Institution

1 Yellow Brick Road

Narnia

Neverland

01234

Street

City/Town

State

Zip Code

3. Date(s) of treatment or time period **1/2/0001 to 2/7/2015**

4. Purpose for which disclosure is to be made: **Cyborg Eligibility**

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: **mark.zuckerburg@myspace.com**

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.

Ron Swanson

01/02/03

John F. Kennedy

Signature of Patient, Parent or Legally Appointed Representative

Date / Time

Print Patient's Name

Katy Perry

Print name of Parent or Legally Appointed Representative (if applicable)

Godmother

Relationship to Patient