



AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Home Phone: _____

Address: _____
Street City State Zip

I hereby authorize BVCHC to: (Please check one of the following)

<input type="checkbox"/> Release my Medical Record to:	<input type="checkbox"/> Obtain my Medical Record from:
_____	_____
Provider/Legal Guardian/Representative/Facility/Organization/Company	Phone Fax
_____	_____
Street	City State Zip code

Check Confidential Information to be Released or Obtained:

COPY FEE: The fee for copies of medical records is based on labor and materials costs as defined by the Omnibus Ruling

Health Record (Date (s) of Service): from (date) _____ to (date) _____

Entire Record, or specifically

Problem List Immunization Record Most recent History & Physical Prenatal Record/OB GYN Abstract Medication List

Progress Notes Laboratory Results X-ray & Imaging Reports Consultation Reports Other: _____

The Purpose of this information is for:

Personal Use Transfer of Care Attorney/Legal Disability Insurance School Worker's Compensation Other _____

If for Transfer of Care- I am transferring the following service (s) provided to me by BVCHC:

Primary Care/Pediatrics/Adult Medicine Family Planning/OBGYN Dental Behavioral Health All Services

I will be continuing the following service (s) at BVCHC:

Primary Care/Pediatrics/Adult Medicine Family Planning/OBGYN Dental Behavioral Health Optometry

Authorization to Release Protected Information

My initials below indicate that I permit the following information, if applicable in my health record, to be released:

_____ Mental Health or Psychotherapy Notes/Information	_____ Genetic Testing	_____ HIV Tests & Related Information
_____ Alcohol and/or Substance Abuse Treatment Notes	_____ Sexual Abuse	_____ Sexually Transmitted Disease (STD's)
_____ Social Worker Communication	_____ Developmental Disability	_____ Other _____

I understand that my records are processed under RI General Laws 5-37.3 and 40.1-5, Federal Privacy Regulations 45 CFR 160-164 and **cannot be disclosed without my written consent except as otherwise specifically provided by law.** I also understand that if my records involve alcohol or drug abuse, or HIV (AIDS) testing, they are further processed under **Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse, and RI Public Law Chapter 88-405, Section 23.** I release The BVCHC and its employees from any liability arising from the release of this information to such persons/agencies, provided that said release of information is done in accordance with applicable law. This consent will have duration of **no longer than one (1) year from the date of this form.** I understand that **I may withdraw my consent in writing at any time. I understand that a withdrawal will not apply to information already released in response to this authorization.** I understand that a withdrawal will not apply to my insurance company, when the law provides my insurer the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or obtain information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it a potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. I understand that my record may contain information that is considered sensitive under the law. PHI cannot be used or disclosed unless you specifically authorize such use or disclosure under 42CFR Part2 of the federal confidentiality regulations. This information shall not be transmitted without specific authorization as provided in these regulations.

Patient's Signature: _____ Date: _____

Parent/Legally Recognized Representative Signature: _____ Date: _____

Created by: 4/16/18 SF revised: 01/14/19/SF _____ Initial (Staff)