



# Authorization for Release or Obtain Protected Health Information

- ALLENBERRY  CENTRAL  CAPITOL HILL  OLNEYVILLE  CHAFEE  CROSSROADS  MET SCHOOL  NORTH MAIN  
 DENTAL  CHAD BROWN

Phone \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

**I authorize PCHC to :**  Release my Medical Record to:  Obtain my Medical Record from:

Name of Facility/Organization/Company \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City State Zip

**The Purpose for this release of information is for:**  Personal Use,  Transfer of Care,  Attorney/Legal,  Disability,  
 Insurance,  School,  Workers Compensation,  Continuity of Care  Other \_\_\_\_\_

**Check Protected Health Information to be Released or Obtained: (State of RI copy fees apply if applicable)**

- Problem List  Immunization Record  Last History and Physical  Prenatal/OB Record  Record Abstract  Entire Record

Dates of service From \_\_\_\_\_ To \_\_\_\_\_ for limited information checked below

- Laboratory Results  X-Ray and Imaging Reports  Ultrasounds/Reports  Consultation Reports  Progress Notes

Other \_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 90 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I may receive a copy of this form.

Information that you authorize to be disclosed may be subject to re-disclosure and no longer protected by law To the extent applicable, I understand that my record may contain information that is considered sensitive under law. PHI cannot be used or disclosed unless you specifically authorize such use or disclosure under 42-CFR Part 2 of the federal confidentiality regulations.

**My initial (s) below, indicate(s) that I permit information of this type, if it exists, to be released:**

- \_\_\_\_ HIV/AIDS(ARC) status/results/treatments/diagnoses/referrals  
 \_\_\_\_ Drug and alcohol abuse status/treatment/diagnoses/referrals  
 \_\_\_\_ Mental Health/psychiatric disorders/treatment/referrals  
 \_\_\_\_ Communicable disease status/results/treatments/diagnoses/referrals

**By signing this statement, I am authorizing release of this information to the requesting party above.**

Signature of Patient or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

If Signed by Legal Representative, Relationship to Patient \_\_\_\_\_ Signature of Witness \_\_\_\_\_

**Mail or Fax To:**  
**Providence Community Health Centers**  
**Attn: Health Information Management Department**  
**375 Allens Avenue, Providence, Rhode Island 02905-5010**  
 Tel: (401) 444-0400 x 3141 Fax: (401) 444-0421

**Office use only MR #** \_\_\_\_\_  
 Date released \_\_\_\_\_ By \_\_\_\_\_  
 ID Verified if in person  Yes  No  
 Legal representative documentation provided if requester is other than patient  Yes  No  
 Fee Collected  Fee Waived