PCHC Site:

PCHC PROVIDENCE COMMUNITY HEALTH CENTERS

Authorization for the Release of Health Information

Patient Name: ____________________

Date of Birth: __________ **Phone:** __________ **Email:** __________

Complete Address: ____________________

This information is to be used for the purpose of: ◯ Personal Use ◯ Transfer of care ◯ Continuity of care ◯ Legal ◯ Disability ◯ School

◯ Workers' Comp ◯ Employment ◯ Immigration ◯ Other: ____________________

I here authorize Providence Community Health Centers, Inc. to:

◯ **RELEASE information from my medical records TO:** ◯ **OBTAIN information FROM:**

Name: ____________________ **Phone:** __________

Address: ____________________ **City/State:** __________ **Zip Code:** __________

Fax: ____________________ **Email:** __________

◯ **Please check here if this authorization is for verbal communication purposes only and copies of records are not being requested.**

Method of Disclosure: ◯ Patient Portal ◯ Mail ◯ Fax ◯ Secure Email: ____________________

◯ Pick-up *(please indicate how you would like to be contacted when ready for pick-up:* __________ ◯ Format: CD-ROM

If for Transfer of Care, which services are you transferring care: ◯ Primary Care ◯ OBGYN ◯ Dental ◯ Specialty Care

Visit Type: ◯ PCP ◯ OBGYN ◯ Behavioral Health ◯ Dental ◯ Specialty: __________

Date(s) of Service: ____________________

Medical Information Requested:

◯ Abstract of Medical Record (2 years) ◯ Problem List ◯ Immunization Record ◯ History & Physical Exam ◯ Lab Results

◯ Prenatal/OB Record ◯ Medication List ◯ Diagnostic Reports ◯ Consult Reports ◯ Dental Treatment Record/X-rays

◯ Complete Medical Record ◯ Other: ____________________

HIV, Behavioral Health, Drug/Alcohol Information contained within the medical records indicated above will be release through this authorization unless otherwise indicated below. **Indicate which you do NOT want released:**

◯ HIV ◯ Substance Abuse (which includes Alcohol & Drug Abuse) ◯ Pregnancy Test ◯ Genetic Testing

◯ Behavioral Health ◯ Sexually Transmitted Disease ◯ Other (please list): ____________________

I understand that:

This authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting in writing PCHC's Health Information Department. Cancellation of the authorization will not apply to information that has already been released based on this authorization.

The information disclosed in response to this authorization may be subject to re-disclosure by recipient and will no longer be protected under the terms of this authorization or be federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and behavioral health information.

That this authorization is voluntary and my treatment by PCHC is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records related to treatment(s) for which the minor may provide consent under Rhode Island state law. If HIV, STD, Title X, or alcohol and/or drug abuse treatment is contained within the requested records, signature of the minor patient who gave legal consent for testing, examination, or treatment is required.

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

Printed Name: ____________________ Date: __________

Signature of Patient of Authorized Representative: ____________________

Please check relationship to patient: ◯ Self ◯ Parent ◯ Legal Guardian ◯ Executor/Administrator of Estate ◯ Healthcare Representative

◯ Other Authorized Legal Representative: ____________________

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Printed Name of Minor (when applicable) Signature of Minor (when applicable) Date

OFFICE USE ONLY: MR #: __________ ID Verified: Yes / No Date Released: __________

Legal Representative documentation provided: Yes / No HIM Staff: __________