AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

	Last	First		MI
Address:				
	Street			
	City	State		ZIP
Date of Birth:		Telephone #:		
	Month/Day/Year		(Area Code) Number	
(Patient, Parent, 6	Guardian or Legal Rep.)	authorize		
(, , , , , , , , , , , , , , , , , , ,	section of seguinep.	(Name of physician / health care p	provider) Phone	# Fax #
o RELEASE to:	Dr. Thomas Rocco 300 Toll Gate Road, Suite	- 204	Phone:	401-921-5791
	Warwick, RI 02886	e 201	Fax:	401-921-5829
ate(s) of Service:				
Progress r Laborator History & Operative	y data physical	Discharge summary Treatment plan Medication notes/shee	ts	
Operative	Reports	Entire Medical Record		
be disclosed for th	e following purpose(s):			
inderstand that my	medical record may contain	information that is considered sensitive up	doules. M. I. I.	
ark(s) below indicati	e that I <u>do not</u> permit infor	n information that is considered sensitive un mation of this type, if it exists, to be released	der law. My check	
Psychologi	e that I <u>do not permit inforr</u> ical / psychiatric conditions	mation of this type, if it exists, to be released Drug and/or alcohol abo	d or requested: use diagnosis and/or t	reatment
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300 Toll Gate Road, Suite 201

Warwick, RI 02886

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