AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last First MI

Address: _____
Street

_____
City State ZIP

Date of Birth: _____ Telephone #: _____
Month/Day/Year (Area Code) Number

I,_____ authorize _____
(Patient, Parent, Guardian or Legal Rep.) (Name of physician / health care provider) Phone # Fax #

to RELEASE to: **Dr. Thomas Rocco**
300 Toll Gate Road, Suite 201
Warwick, RI 02886

Phone: 401-921-5791
Fax: 401-921-5829

Date(s) of Service: _____

Information pertaining to my identity, prognosis, diagnosis or treatment. The information to be released shall include:

- ☐ Progress notes
- ☐ Laboratory data
- ☐ History & physical
- ☐ Operative Reports
- ☐ Discharge summary
- ☐ Treatment plan
- ☐ Medication notes/sheets
- ☐ Entire Medical Record

To be disclosed for the following purpose(s): _____

I understand that my medical record may contain information that is considered sensitive under law. My check mark(s) below indicate that I **do not** permit information of this type, if it exists, to be released or requested:

- ☐ Psychological / psychiatric conditions
- ☐ HIV / AIDS diagnosis and/or testing
- ☐ Genetic Testing
- ☐ Drug and/or alcohol abuse diagnosis and/or treatment
- ☐ Sexually transmitted disease(s)
- ☐ Abortion
- ☐ Rape / Sexual abuse

Expiration Date:_____ (if blank, one year from date of signature)

Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit redisclosure.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____
Signature Date Signature of Parent, Guardian or Legal Rep. (if needed)