Lifespan Medical Imaging
Rhode Island Hospital • The Miriam Hospital
Newport Hospital
Delivering health with care.®

Authorization to Disclose Protected Health Information

(This form must be completed in full before signing)

PATIENT NAME: _____ PATIENT DOB: _____

ADDRESS: _____ PATIENT PHONE: _____

PATIENT MRN# _____ DATE REQUESTED _____

I hereby authorize Lifespan Medical Imaging to obtain from and/or release to:

_____

Person/Place/Information

_____

Street City State Zip Phone

Dates of treatment or time period _____

Purpose for which disclosure is to be made: ☐ Coordination of Care ☐ Patient Request ☐ Legal

Other (please specify) _____

I do not want the following information disclosed: ☐ mental health ☐ alcohol/drug use/test
☐ sexual abuse ☐ sexually transmitted infections ☐ AIDS/HIV test results

TYPE OF RECORDS REQUESTED: ☐ REPORTS ☐ CD ☐ SPECIAL REQUESTS _____

METHOD OF RELEASE: ☐ PT PICK UP ☐ COURIER ☐ MAIL ☐ FED EX ☐ OTHER

Other _____

- I understand that my records are protected under the federal privacy laws and regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse.
- I understand that if the person(s) or entity (ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Lifespan, its employees and my physicians from all liability arising from this disclosure of my health information.
- It is my understanding that this authorization is for information we have at the time of your request, only for the information requested above and will expire 90 days from the date signed below. I understand that I may revoke this authorization by notifying Lifespan in writing. I understand that any previously disclosed information would not be subject to my revocation request.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits, unless otherwise described in the space provided here:

_____ _____

Signature of Patient*, Legal Guardian, or Representative, Courier Date/Time

_____ _____

Print name of Patient, Legal Guardian or Representative, Courier Date/Time

*Note concerning minors: For disclosures to persons/entities other than medical providers, the signature of a patient under 18 years who gave legal consent for testing, examination or treatment for reportable communicable disease (including HIV and venereal disease) or for alcohol and/or drug abuse treatment is required.

To be completed by DI Medical Records: RECORD RELEASED BY: _____ ID VERIFIED BY: _____