CLIENT'S NAME:_____

Individual / Organization

_____

_____

_____

_____

Dear _____;

The attached is the Rhode Island Authorization for Disclosure/Use of Health Information Form.
As noted in Part IV, the form authorizes the release of all information (except as noted by the client).
Section V further notes that the release covers all the medical/health care providers, including, but not limited to the provider listed in Section II.

For our purposes we are only requesting the following records:

- ☐ Discharge Summary w/lab data
- ☐ History & Physical Exam
- ☐ Progress notes
- ☐ Lab data
- ☐ X-rays
- ☐ Diagnostic test reports
- ☐ Psychiatric exam/evaluation
- ☐ Treatment plan
- ☐ Medical
- ☐ Nurses notes
- ☐ Psychological test
- ☐ Consultative reports
- ☐ Physical/Occupational therapy progress notes
- ☐ Educational
- ☐ Financial
- ☐ Social Service history
- ☐ Billing statements
- ☐ Dietary
- ☐ Dental
- ☐ Photos/Videos/Digital images
- ☐ Emergency care records
- ☐ Care plans
- ☐ MDS (minimum data set)
- ☐ Other:

Time Frame:_____
_____

Please forward records to: _____
_____
_____

**RHODE ISLAND**
**AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION**

**DIRECTIONS:** COMPLETE ALL SECTIONS, DATE, AND SIGN

**I.** I, _____, hereby voluntarily authorize the disclosure of
*(Name of Applicant/Patient)*
information from my record.

My Date of Birth: _____/_____/_____ My Social Security Number: _____-_____-_____

**II.** **My information is to be disclosed by:**

_____
*(Name of Person/Organization)*

_____
*(Address)*

_____
*(City, State, ZIP)*

**And is to be provided to:**

_____
*(Name of Person/Organization)*

_____
*(Address)*

_____
*(City, State, ZIP)*

**III.** **The purpose or need for this release of information is:**

☐ I am applying for Medical Assistance
☐ I am applying for DHS Services
☐ My own personal and private reasons
☐ Other *(specify)*: _____

**IV.** **The information to be disclosed:** *(check only ONE of the following boxes)*

☐ Entire Health Record
☐ Health Insurance Information
☐ All of the information (except the boxes I checked) in Section VI below
☐ Other *(specify)*: _____
☐ **Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)**

**I would also like the following sensitive information disclosed** *(check the applicable box(es))*

☐ Alcohol/Drug Abuse Treatment/Referral
☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases
☐ Mental Health (Other than Psychotherapy Notes)

**V.** I understand that if I am applying for enrollment, recertification, or other services, this release covers all my medical/health care providers, including the provider named above as well as any other person, facility, program or plan I have told you about on my written applications(s), and on the necessary forms. I understand further that this authorization is required as a condition of obtaining eligibility and services and shall be used by the recipient only for such purposes. Therefore, failure on my part to sign this authorization may affect my eligibility and/or the scope of services I may obtain. Additionally, I agree to the use of a fax or a photocopy of this form for the release or disclosure of the information.

I also understand that I may revoke this authorization in writing at any time to the recipient and that, if I do, the individual or organization may condition my eligibility and access to services on my decision to revoke. In addition, any information disclosed to recipient before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below.

*(Enter if different from one year after the date below)* _____

_____ _____
**Signature of Patient** **Date**

_____ _____ _____
**Signature of Authorized Representative** **Relationship to Patient** **Date**

**VI. Specific Information I do <u>NOT</u> want disclosed**: *(check the applicable box(es))*

| | | | |
|---|---|---|---|
| ☐ Discharge Summary w/lab data | ☐ Progress Notes | ☐ Laboratory Data | ☐ Psychiatric Exam |
| ☐ History & Physical Examination | ☐ Treatment Plan | ☐ Psychological Test | ☐ Social Service History |
| ☐ Vocational | ☐ Medical | ☐ Educational | ☐ Financial |
| ☐ Minimum Data Set | ☐ Nurses' Notes | ☐ Care Plans | ☐ Dental Records |
| ☐ Photos/Videos/Digital Images | ☐ Billing Statements | ☐ Consultant Reports | ☐ Dietary Records |
| ☐ Emergency Care Records | ☐ X-ray Reports | ☐ Diagnostic Results | |