Authorization For Use or Disclosure of Medical Record Information

Center for Obstetrics & Gynecology

297 Promenade Street, Providence, RI 02908

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby Authorize Center for OB/GYN to: ____ release my medical record information to ____obtain from:

☐ Mail Copies To: ☐ Hold for Patient Pick-up ☐ Discuss Medical Information With:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ◯ Personal ◯ Continuing Care (second opinion or refer to specialist) ◯ Insurance ◯ Legal
◯ Transfer out of Practice / reason?_____ ◯ Other _____

Information to be Released

◯ Please provide a 2 year abstract (includes 5 years of diagnostics)
Copy fee capped at $20.00 for a 2 year abstract

◯ Other - Please be specific, include dates and MD's under comments-
Note: You will be invoiced at the allowable RI Statute rate:
RI Statute Copy Fee: $15.00 clerical fee, plus $.25 per page for first 100 pages, $.10 for any pages over 100, plus *postage*

Comments

Center for OB/GYN does not provide copies of records received for another physician or institution.
Please request these records directly from the original healthcare provider.

Authorization to Release Protected Information

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one *Initial each line below to confirm your choices*

I ☐ **DO** ☐ **DO NOT** want ***Psychiatric Treatment Notes** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests & Sexually Transmitted Disease (STD)** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____
I ☐ **DO** ☐ **DO NOT** want information about _____ released _____
Other sensitive information?

STOP

Please confirm that you have put a checkmark and initialed **ALL** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected infomation is not released, we may be unable to fulfill this request.

Sign Here **Date Here**

Patient's Signature **Date***

Parent/Legally Recognized Representative Signature** **Date****

Witness **Date**

Know Your Privacy Rights
Refer to the HIPAA
"PRIVACY NOTICE"

*This Authorization is valid for one year (30 days for alcohol/drug abuse treatment) unless you specify other wise: You may revoke this Authorization at any time by providing a written statement to Center for OB/GYN , except to the extent that we have already completed action on it.
** By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following:
The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Center for OB/GYN will not condition treatment on payment of the provision of this Authorization.