Blackstone Valley Community Health Care

Authorization for the Release of Health Information

Patient Name: _____Date of Birth: _____Home Phone: _____

Address: _____
Street City State Zip code

I hereby authorize BVCHC to: (Please check one of the following)

☐ **RELEASE** my Medical Record to: ☐ **OBTAIN** my Medical Record from:

_____
Name/Legal Guardian/Representative/Facility/Organization/Company Phone Fax

_____
Street City State Zip code

Method of Disclosure: ☐ Fax ☐ Mail ☐ Pick-up

☐ Please check here if this authorization is for verbal communication purposes only and copies of records are not being requested.

The Medical Information to be Released or Obtained:

COPY FEE: The fee for copies of medical records is based on labor and materials costs as defined by the Omnibus Ruling

☐ Health Record (Date (s) of Service): from (date) _____ to (date) _____
☐ Problem List ☐ Immunization Record ☐ Most recent History & Physical ☐ Prenatal Record/OB GYN ☐ Abstract (2 years) ☐ Medication List
☐ Progress Notes
☐ Laboratory Results ☐ X-ray & Imaging Reports ☐ Consultation Reports ☐ Dental Records ☐ Dental X-ray ☐ Other: _____

The Purpose of this information is for:

□ Personal Use □ Transfer of Care □ Attorney/Legal □ Disability □ Insurance □ School □ Worker's Compensation □ Other_____
If for Transfer of Care- I am transferring the following service (s) provided to me by BVCHC:
□ Primary Care/Pediatrics/Adult Medicine □ Family Planning/OBGYN □ Dental □ Behavioral Health □ All Services

I will be continuing the following service (s) at BVCHC:
□ Primary Care/Pediatrics/Adult Medicine □ Family Planning/OBGYN □ Dental □ Behavioral Health □ Optometry

HIV, Behavioral Health, Drug/Alcohol Information contained within the medical records indicated above will be release through this authorization unless otherwise indicated below

Do NOT Release Protected Information

My initials below indicate that I DO NOT permit the following information, if applicable in my health record, to be released:

_____ Behavioral/Mental Health or Psychotherapy Notes/Information _____ Genetic Testing _____ HIV Tests & Related Information
_____ Alcohol and/or Substance Abuse Treatment Notes _____ Sexual Abuse _____ Sexually Transmitted Disease (STD's)
_____Social Worker Communication _____Developmental Disability _____ Other_____

I understand that my records are processed under RI General Laws 5-37.3 and 40.1-5, Federal Privacy Regulations 45 CFR 160-164 and **cannot be disclosed without my written consent except as otherwise specifically provided by law**. I also understand that if my records involve alcohol or drug abuse, or HIV (AIDS) testing, they are further processed under **Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse, and RI Public Law Chapter 88-405, Section 23.** I release The BVCHC and its employees from any liability arising from the release of this information to such persons/agencies, provided that said release of information is done in accordance with applicable law. This consent will have duration of **no longer than one (1) year from the date of this form**. I understand that **I may withdraw my consent in writing at any time. I understand that a withdrawal will not apply to information already released in response to this authorization.** I understand that a withdrawal will not apply to my insurance company, when the law provides my insurer the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or obtain information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it a potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. I understand that my record may contain information that is considered sensitive under the law. PHI cannot be used or disclosed unless you specifically authorize such use or disclosure under 42CFR Part 2 of the federal confidentiality regulations. This information shall not be transmitted without specific authorization as provided in these regulations.

Patient's Signature: _____ Date: _____

Parent/Legally Recognized Representative Signature: _____Date: _____

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