Miriam Hospital
A Lifespan Partner

Women's Medicine Collaborative
146 West River Street
Providence, RI 02904
Phone: (401) 793-5700
Fax: (401) 793-7555

AUTHORIZATION FOR USE OF PROTECTED HEALTH CARE INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Phone _____

1. I authorize _____
Name of Person / Place / Institution

_____
Street City/Town State Zip Code

2. to ☐ **Release to**: Women's Medicine Collaborative, 146 West River Street, Providence, RI 02904

3. Date(s) of treatment or time period _____

4. Purpose for which disclosure is to be made _____

5. Information to be disclosed (check all applicable):
☐ Emergency Department Record ☐ Operative/Path Report ☐ Lab / X-Ray Reports ☐ Clinic Report
☐ Discharge Instructions ☐ Discharge Summary ☐ Entire Medical Record
☐ Continuity of Care Document (CCD) ☐ Other _____
☐ Abstract* (*includes: face sheet, emergency dept. record, discharge summary, consult, operative report, pathology report, test results)

6. Please check one: I hereby ☐ **Consent to** ☐ **Refuse**
the release of confidential information concerning: mental health, alcohol and/or drug use, sexual abuse, venereal disease, AIDS or HIV test results.

7. 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.

8. 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 The Women's Medicine Collaborative, The Miriam Hospital, its employees and my physicians from all liability arising from this disclosure of my health information.

9. It is my understanding that this authorization will expire 90 days from the date signed below. I understand that I may revoke this authorization by notifying The Women's Medicine Collaborative/The Miriam Hospital in writing. I understand that any previously disclosed information would not be subject to my revocation request.

10. 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:

_____

This form must be fully complete before signing. Please Note: There may be a fee associated with copying your medical record.

_____ _____ _____ _____
Signature of Patient, Parent, or Patient's Legal Representative Date Time Print Patient's Name

_____ _____
Print Name of Parent or Legally Appointed Representative (if applicable) Relationship to Patient

Original – Chart Copy – Patient

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