



# Lifespan Physician Group, Inc.

## 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: Lifespan Physician Group, Inc., One Randall Square, 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
- Discharge Instructions
- Continuity of Care Document (CCD)
- Abstract\* (\*includes: face sheet, emergency dept. record, discharge summary, consult, operative report, pathology report, test results)
- Operative/Path Report
- Discharge Summary
- Other \_\_\_\_\_
- Lab / X-Ray Reports
- Entire Medical Record
- Clinic Report

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