REHABILITATION HOSPITAL OF RHODE ISLAND
HEALTH INFORMATION MANAGEMENT
116 EDDIE DOWLING HIGHWAY
NORTH SMITHFIELD, RI 02896

AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ **TELEPHONE:** _____

I hereby authorize the ***Rehabilitation Hospital of Rhode Island*** regarding my protected health information to:

( ) Release to: NAME:_____

( ) Obtain from: ADDRESS: _____

CITY/STATE: _____

Date of Service: _____

The following information: (Check one)

☐ Discharge Summary ☐ History & Physical ☐ Consultation Reports

☐ Other (specify)_____

by means of telephone, reproduction, or facsimile transmission for the purpose of:

( ) patient care
( ) other (Please be specific): _____ _____

I understand that my records are protected under the federal confidentiality regulations of alcohol and drug abuse treatment (42 CFR, Part 2) and/or the General Laws of the State of Rhode Island. I also understand that further disclosure of this information is not permitted without my express, written authorization. If I share this information with any other party or organization not listed on this authorization, I understand that it is no longer protected by law (HIPAA Privacy Regulation).

I have read carefully, or have been read to, and understand the above statements and voluntarily consent to disclose the above information and/or medical records to those persons/agencies named above. This includes alcohol/drug abuse records, mental health records, and HIV (AIDS) results.

I release the Rehabilitation Hospital of Rhode Island and its employees from any liability arising from the release of the protected health information to such persons/agencies, provided the said release of information is done substantially within applicable law.

I understand that I may revoke this consent at any future time, except to the extent that action has been taken in reliance on this authorization and that it will automatically expire 90 days after it is signed or after above have been accomplished. I understand that I must notify Rehabilitation Hospital of Rhode Island of my revocation in writing.

Signed: _____ Date/Time:_____
(patient)

Or: _____ As: _____
(Other responsible party) (Relationship to Patient)

Witness: _____ Date/Time:_____

Reason Patient Cannot Sign: _____