Cardiovascular Associates
OF RHODE ISLAND

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AUTHORIZATION FOR USE/RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name_______________________________________ DOB: _________________________
Address ____
____

1) I authorize _________________________________ to disclose my health information specific to the following date or time period: ____
2) Individual or entity authorized to receive my health information:_________________
____
____
____

3) Purpose for which disclosure is to be made:___________________________________
____

4) Description of information that may be used/disclosed:
Entire Medical Record History & Physical Notes
Laboratory Results EKG & Testing Results
Other

5) To the extent applicable, I understand that my medical record may contain information that is considered sensitive under law. I do not permit the following information to be released if it exists_______________ By leaving this blank I understand that all information will be released.

6) I understand that my medical records are protected under the federal privacy laws and regulations and under the General laws of Rhode Island, and cannot be released without my written consent except as otherwise specifically provided by law.

7) I understand that if the person (s) or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore I release____________________________ its employees and my physician from all liability arising from this disclosure of my health information.

8) It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing,__________________________. I understand that any previously disclosed information would not be subject to my revocation request.

9) 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 completed before signing.

______________________________________ ______________________________
Signature of Patient or Legal Representative Print Patient's Name

______________________________________ ______________________________
Print Name of Legal Representative (if applicable) Relationship to Patient

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