Office of Health Services
Salve Regina University
100 Ochre Point Avenue
Newport, RI 02840
Phone (401)341-2904 FAX (401)341-2934

AUTHORIZATION TO RELEASE INFORMATION

Name_____ DOB_____ Phone #_____

I hereby request and authorize:

_____ (staff member)

_____To release information to _____to receive from _____to exchange with

Name/Organization_____ Phone_____

Address _____ Fax _____

The following specific information from my records:

Dates of Treatment: _____

INFORMATION TO BE RELEASED OR EXCHANGED:

____Complete Health Record ____Mental Health Evaluation ____Laboratory Tests/Radiology Reports

____Verbal Information ____Progress Notes ____Immunization Record

____Other _____

The purpose of this disclosure is_____

I understand that I may revoke this Authorization at any time by providing a written notice to the Office of Health Services. The revocation will not apply to information that has already been released by this authorization.

I understand that my information may be redisclosed by the authorized person/organization receiving the information and, at that point, the information may no longer be protected under the terms of this agreement.

If the patient is under 18 years of age, this release may be signed by a parent/guardian but will expire upon patient reaching majority age.

Patient Signature_____Date_____

or, Legal Representative_____ Relationship to Patient_____

THIS AUTHORIZATION IS EFFECTIVE FOR ONE YEAR FROM DATE OF SIGNING OR AS SPECIFIED BELOW

_____

One Year Release Cover Sheet

The attached one year authorization to release health information entitles the named person:

To request a copy of medical records after a patient visit or periodically throughout the year

To receive information over the phone regarding a prior visit by the patient

To consult with provider(s) regarding a visit by the patient

Medical records will not be automatically released upon a visit, nor will the Health Services Center automatically notify the named person of a visit by the patient.

The release is valid for only one year, unless a shorter amount of time is specified. Periods over one year are not permissible. A new release must be signed each year.

The patient may revoke or limit this authorization at any time by written notice to the Office of Health Services.

For patients under the age of 18, a parent or guardian may sign the release but the release will expire upon the patient reaching majority age.