RHODE ISLAND **MEDICAL IMAGING**

## Authorization for Use or Disclosure of Protected Health Information

PATIENT NAME:
LAST_____FIRST_____MI_____

DATE OF BIRTH:_____-_____-_____MEDICAL RECORD NUMBER:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

DAY PHONE:_____OTHER PHONE:_____

I hereby authorize **Rhode Island Medical Imaging, Inc.** to obtain, retrieve, use or disclose my protected health information as indicated below:

NAME / FACILITY:_____ATTENTION:_____

ADDRESS:_____CITY:_____STATE:_____ZIP_____

**INFORMATION TO BE RELEASED:**

- ☐ Entire Medical Record (includes reports and images)*
- ☐ Report(s) Only:*
  _____
- ☐ Images Only:*
  _____
- ☐ Billing Records:*
  _____
- ☐ Other: *
  _____

*Please include specific exam information, for example: dates of service, date range (previous two years) or nature of study (all mammography studies) etc.

**PURPOSE OF DISCLOSURE:**

- ☐ At my (patient) request
- ☐ Changing Physician
- ☐ Changing Imaging Center
- ☐ Workers' Compensation
- ☐ Second Opinion
- ☐ Legal
- ☐ Insurance
- ☐ Other_____

**AUTHORIZATION TO RELEASE PROTECTED INFORMATION:**
*__Required:__ - Please complete the statements below by **CIRCLING** how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

I **DO** **DO NOT** want **Psychiatric Treatment Notes** released.
I **DO** **DO NOT** want information about **Mental Health** released.
I **DO** **DO NOT** want information about **HIV Tests and Related Information** released.
I **DO** **DO NOT** want information about **Alcohol and/or Substance Abuse** released.

*Please confirm and **initial** that you have circled ALL of the protected information categories above regardless if they are applicable or not. If this form is incomplete, or if protected information is not released, we may be unable to fulfill the request. _____
***Your initials here.***

1. I understand that this authorization will expire one year from the date of signing unless you specify otherwise. You may revoke this Authorization at any time. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Rhode Island Medical Imaging, Inc. in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I will get a copy of this form after I sign it.

**By signing below, I acknowledge that I have read and understand this Authorization.**

_____ _____ _____
SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE | PRINT NAME | DATE

IF NOT SIGNED BY PATIENT, INDICATE RELATIONSHIP TO PATIENT OR OTHER AUTHORITY TO ACT:_____