WOOD RIVER HEALTH

823 Main Street, Hope Valley, RI 02832
Phone: (401) 539-2461 Fax: (401) 539-2490
www.woodriverhealth.org

Authorization To Release Protected Health Information

Patient Name: Date of Birth:

Address:

Phone:

PLEASE NOTE THERE IS A $15.00 CHARGE IF YOU ARE PICKING UP A COPY OF YOUR RECORDS

I Authorize Wood River Health ☐ To **RELEASE** my Medical Records OR ☐ **OBTAIN** my Medical Records

If picking up records indicate pickup location: ☐ 823 Main St, Hope Valley OR ☐ 17 Wells St #202, Westerly

In order to process the request you must complete **ALL** information below in its entirety:

Provider Name:

Practice Name:

Address:	City, State, Zip Code:
Telephone Number:	Fax Number:

Check confidential Information below to be released or obtained:

☐ All Medical Records
☐ All Dental Records
☐ Immunizations
☐ Lab results (HIV Only upon request)
☐ Dental X-Rays
☐ Social Services

Other, Please Specify_____

For the dates of service from_____to _____

Reason for Requesting Records (check all that apply)

☐ Terminating from WRH ☐ Seeking additional services ☐ Seeking specialist services
☐ Seeking second opinion ☐ Other, Please explain_____

I understand that I have a right to revoke this authorization at any time I understand that if I revoke this authorization I must do so in writing. To obtain a copy of a revocation from I may contact the Privacy Officer. I understand that the revocation will not apply to information that had already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 6 months. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

To the extent applicable, I understand that my record may contain information that is considered sensitive under law. My initials below indicate that I permit information of this type, if it exists, to be released.

____Alcohol/Drug diagnosis/treatment ____Mental Health diagnosis/treatment/referral_____HIV/AIDS diagnosis/treatment
____Diagnosis/Treatment relating to communicable diseases

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If signed by Legal Representative) Signature of Witness

*This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Pat 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to who it pertains or as otherwise permitted by 42 C.F.R. Part 2