



REQUEST TO RELEASE PATIENT HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: () _____

Address: _____

City: _____ State: _____ Zip: _____

RECIPIENT

I authorize _____ to release my health information:

Delivery Preference: Pickup Mail Secure Email Fax (for Medical Care purposes) - Fax Number: 401.415.8608

Pick up will be by myself or other (name): _____

Secure Email Address: PatientAdvocate@BioMedNE.com

Mailing address: **The BioMed Center
111 Chestnut St.
Providence, RI 02903**

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ to _____

Abstract *OR* check only those documents needed:

- | | |
|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Dental Reports |
| <input type="checkbox"/> Patient Notes | <input type="checkbox"/> Radiographs/Imaging |
| <input type="checkbox"/> Laboratory/Pathology Reports | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Records from a specific provider: _____ |

SENSITIVE HEALTH INFORMATION

The following types of information will be released UNLESS you place your initials in the space provided:

- | | |
|---------------------------------------|--|
| _____ Mental health treatment records | _____ Sexually Transmitted Disease (STD) treatment records |
| _____ Genetic testing | _____ Alcohol/drug abuse treatment records |
| _____ HIV/AIDS test results | |

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date). You or your Personal Representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

SIGNATURE

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority