Bradley Hospital
1011 Veteran's Memorial Parkway East Providence, Rhode Island 02915
Authorization to Use or Disclose Health Information

patient:_____ **date of birth:**_____

I hereby authorize Bradley Hospital to ☐ disclose to ☐ obtain from

name/agency:_____ tel #:_____

address:_____

health information concerning the above named individual including
☐ discharge summary ☐ discharge instructions ☐ initial evaluation
☐ psychological testing ☐ _____

for date of service: ☐ current episode ☐ most recent ☐ _____

for the purpose of ☐ patient care ☐ _____

method of disclosure ☐ verbal/telephone ☐ photocopy ☐ fax

This authorization does not extend to information concerning ☐ HIV/AIDS infection
☐ alcohol or drug abuse treatment ☐ sexually transmitted diseases

I understand that these records are protected under Rhode Island General Law and Federal Privacy Regulations and cannot be disclosed except as specifically provided by law. I understand further that these records may include information regarding alcohol or drug abuse, which are protected under 42 CFR Part II, Confidentiality of Alcohol and Drug Abuse Patient Records.

I understand that if the recipient of this information is not a health care provider or health plan covered by federal privacy regulations, this information may be re-disclosed and is no longer protected by those regulations. Therefore, I release Bradley Hospital, its employees and physicians from all liability arising from this disclosure.

I understand that this authorization will expire one year from the date signed. 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 Health Information Services at Bradley Hospital. I understand that any previously disclosed information would not be subject to a revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect the ability of the individual to whom it pertains to obtain treatment, payment or eligibility for benefits unless otherwise described in the space provided here:

_____

_____ _____
signature of patient, parent or legal representative date

_____ _____
print name relationship to patient

_____ _____
signature of witness date