Lifespan Physician Group, Inc.

W. Curt LaFrance Jr., MD, MPH
RIH Division of Neuropsychiatry
593 Eddy Street, Potter 3
Providence, RI 02903
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AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Phone Number _____

Date of Birth _____ Medical Record # (or SS #) _____

1. I authorize Lifespan Physician Group, Inc., and the Departments of Psychiatry and Neurology of Rhode Island Hospital, to disclose my health information to:

   _____

   AND/OR

   I authorize: Dr/Hospital _____ phone/fax_____ to disclose my health information to Lifespan Physician Group, Inc., and the Departments of Psychiatry and Neurology of Rhode Island Hospital, Division of Neuropsychiatry at 593 Eddy Street – Potter 3, Providence, Rhode Island 02903, **ATTN: W. Curt LaFrance Jr., MD. fax: 401-444-3298**

2. For the following date or time period: ____date of birth_____to present___
3. Purpose for which disclosure is to be made: __patient care_____
4. Method of Release: __X__ Telephone/Verbal __X__Fax __X__ Photocopies _X_ Electronic
5. Information to be disclosed/received (check all applicable):

☑ Entire Medical Record	☑ Neuropsychological Testing	❑ Progress Notes
❑ Emergency Dept. Record	❑ Neurological Workup	☑ Psychological Tests
❑ Discharge Summary	❑ Medication List	❑ Laboratory Data
❑ Radiology Report	❑ History & Physical Exam	❑ Treatment Plan
❑ EKG	❑ Emergency Dept. Record	☑ Psychiatric Examination
❑ EEG	❑ Pathology Report	❑ Other (please specify)_____
❑ MRI/CT	❑ Operative Report	
❑ EMG	❑ Consultation	

6. **I understand that this will include health information relating to**:

   Mental Health (including psychotherapy notes) — Treatment for alcohol and/or drug abuse
   HIV (Human Immunodeficiency Virus) infection — Sexually Transmitted Disease

7. I understand that my records are protected under the federal privacy regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law. Further, I understand that if my records involve alcohol or drug abuse, they are also protected under the Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.
8. I understand that if the person(s) or entity(ies) receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Lifespan Rhode Island Hospital/Dept. of Psychiatry, its employees and my physicians from all liability arising from this disclosure of my health information.
9. It is my understanding that this authorization will expire 1 year from the date signed below. I understand that I may revoke this authorization by notifying Lifespan Rhode Island Hospital/Dept. of Psychiatry in writing. I understand that any previously disclosed information would not be subject to my revoke request.
10. I understand that my de-identified information may be used for medical education, research, and medical journal publications.
11. I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or Medical Records to those persons/agencies named above.

This form must be fully complete before signing.

_____ _____
Signature of Patient or Patient's Legal Representative — Date

_____
Print Patient's Name

_____ _____
Print Name of Legal Representative (if applicable) — Relationship to Patient