The Miriam Hospital
A Lifespan Partner

The Miriam Hospital
Health Information Services
164 Summit Avenue
Providence, RI 02906
Tel: 401 793-2222 Fax: 401.793.2247

AUTHORIZATION FOR USE OF PROTECTED HEALTH CARE INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Phone _____

1. I authorize The Miriam Hospital to ❒ Release To:
2. _____
   Name of Person / Place / Institution

   _____
   Street City/Town State Zip Code
3. Date(s) of treatment or time period _____
4. Purpose for which disclosure is to be made: _____
5. Information to be disclosed (check all applicable):

   ❒ Emergency Dept. Record ❒ Operative/Path Report ❒ Lab/X-ray Reports ❒ Clinic Report
   ❒ Abstract* ❒ Discharge Summary ❒ Entire Medical Record ❒ Other _____
   *abstract includes: Facesheet, ED record, D/C Summary, Consult, Operative report, pathology report, test results.
   ❒ Discharge Instructions ❒ Cont. of Care Document (CCD) (❒ check here if you would like either of these sent electronically)
   Email address: _____

6. Please check one: I hereby ❒ Consent to ❒ Refuse
   to the release of confidential information concerning: mental health, alcohol and/or drug use, sexual abuse, venereal disease, AIDS or HIV test results
7. I understand that my records are protected under the federal privacy laws and regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.
8. I understand that if the person(s) or entity(ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release The Miriam Hospital, 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 90 days from the date signed below. I understand that I may revoke this authorization by notifying The Miriam Hospital in writing. I understand that any previously disclosed information would not be subject to my revocation request.
10. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits, unless otherwise described in the space provided here
    _____.

This form must be completed in full before signing. There may be a cost associated with this request.

_____ _____
Signature of Patient, Parent or Patient's Legal Representative Date/Time Print Patient's Name

_____ _____
Print Name of Parent or Legally Appointed Representative (if applicable) Relationship to Patient

Original - Chart Copy - Patient

Rev: 07/2012