



# The Miriam Hospital

*A Lifespan Partner*

Health Information Services  
164 Summit Avenue  
Providence, RI 02906  
Tel: 401-793-2222  
Fax: 401-793-2221

## Authorization for Use of Protected Health Information

Patient Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Medical Record # (or SS #) \_\_\_\_\_

Address \_\_\_\_\_

1. I authorize The Miriam Hospital to disclose my health information specific to the following date or time period

\_\_\_\_\_

2. Individual or entity authorized to receive my health information:

\_\_\_\_\_

3. Purpose for which disclosure is to be made:

\_\_\_\_\_

4. Information to be disclosed (check all applicable):

- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Abstract     | <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Operative Report      | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Laboratory Report       | <input type="checkbox"/> Radiology Report      | <input type="checkbox"/> Pathology Report  |
| <input type="checkbox"/> EKG          | <input type="checkbox"/> Emergency Dept. Record  | <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Other _____       |

**THERE IS A PROCESSING FEE OF \$10.00 AND \$1.00 PER PAGE  
FOR MICROFILM/FICHE RECORDS, THE PROCESSING FEE IS \$10.00 AND \$1.50 PER PAGE**

5. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under law. My check mark(s) below indicate(s) that I **do not** permit information of this type, if it exists, to be released. I understand that if I do not check the box, The Miriam Hospital **will** release such information about me if it exists.

- |  |  |
|--|--|
| <input type="checkbox"/> HIV /AIDS infection | <input type="checkbox"/> Sexually transmitted diseases           |
| <input type="checkbox"/> Mental Health       | <input type="checkbox"/> Treatment for alcohol and/or drug abuse |

6. 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.

7. I understand that if the person(s) or entity(ies) that receives 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 The Miriam Hospital, its employees and my physicians from all liability arising from this disclosure of my health information.

8. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, The Miriam Hospital. I understand that any previously disclosed information would not be subject to my revocation request.

9. 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 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 \_\_\_\_\_

Original - Chart

Copy - Patient