



### Authorization to Use or Disclose Protected Health Information

(This form must be completed in full before signing)

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

ZIP

1. I hereby authorize Gateway Healthcare to:  Release to  Obtain from  Verbal Communication

2. \_\_\_\_\_  
Person / Place / Institution

Street

City

State

ZIP

Phone

3. Dates of treatment or time period \_\_\_\_\_

4. Purpose for which disclosure is to be made:  Coordination of Care  Patient Request  Legal

Other (please specify): \_\_\_\_\_

5. Record Format-please check one:  paper  data storage device

6. Information to be disclosed (check all applicable): There may be a fee associated with this request

Emergency Dept. Record  Operative/Path Report  Lab/X-ray Reports  Other Diagnostic Testing

Clinic/Office Visit  Consultation / Evaluation  After Visit Summary

Discharge Summary  Other \_\_\_\_\_

For Behavioral Health:  Assessment  Treatment Plan  Psychiatric Evaluation  Medications  Progress Notes

7. I do **not** want the following information disclosed:  mental health  alcohol/drug use/test  
 sexual abuse  sexually transmitted infections  AIDS/HIV test results

8. 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. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2. Confidentiality of Alcohol and Drug Abuse.

9. 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 Gateway Healthcare, its employees and my physicians from all liability arising from this disclosure of my health information.

10. It is my understanding that this authorization is for information we have at the time of your request, only for the information requested above and will expire 1 year from the date signed below. I understand that I may revoke this authorization by notifying Gateway Healthcare in writing. I understand that any previously disclosed information would not be subject to my revocation request.

11. 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:

\_\_\_\_\_  
Signature of Patient\*, Legal Guardian, or Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Print name of Patient, Legal Guardian or Representative

\_\_\_\_\_  
Date/Time