Authorization for Disclosure/Use of Health Information

Complete all sections, then sign and date at the end of the form.

Section 1: Requestor

I, ____ hereby voluntarily authorize the disclosure of

(Name of client)

information from my record.

My date of birth:_____________________________ My social security number:_____________________

Section 2: Authorized Recipient and Releaser

My information is to be disclosed to:

Name: ____________________________________

Address: __________________________________

City/State/ZIP: ____________________________

My information is to be released by:

Name: ____________________________________

Address: __________________________________

City/State/ZIP: ____________________________

Section 3: Purpose for release of information

The purpose or need for this information release is:

☐ To obtain the information requested below to assist in my vocational rehabilitation planning

☐ My own confidential reasons

☐ Other, *Specify*: ____

Section 4: Specific information to be released

I would like the following information disclosed from my health record. *Check all boxes that apply.*

☐ Vocational

☐ Medical

☐ Financial

☐ Psychiatric/Psychological

☐ Educational

☐ Social

☐ Other, *Specify:*____

☐ **Psychotherapy notes only.** *By checking this box, I waive my psychotherapist-patient privilege.*

Specific information needed: ____

____

Dates of medical service: __________________ to ____________________

I would also like the following sensitive information disclosed: (*Check any/all boxes that apply.)*

☐ Alcohol/Drug abuse treatment/referral

☐ Sexually Transmitted Diseases

☐ HIV/AIDS-related treatment

☐ Medical Marijuana Program

Section 5: Agreement

I understand that I may revoke this authorization in writing at any time to the Rhode Island Department of Health (RIDOH).Any information disclosed to RIDOH before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], *and the* Privacy Act of 1974 [5 USC 552a]. *If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below. Any information released or received as a result of this consent shall not be further relayed in any way to any person or organization outside RIDOH without additional written consent from me.*

____

Signature of records requestor *Date*

____

Signature of authorized representative *Relationship to client* *Date*

Expiration date, if different than one year from date of signature: ______________________________

Continued on next page

State of Rhode Island, County of ____

On this ______ day of ____________, 20___, before me personally appeared ______________________________, personally known to the notary or proved to the notary through satisfactory evidence of identification, to be the person whose name is signed on the preceding or attached document in my presence.

Signature of Notary Public: ____

Printed name, Notary Public: ____________________________________ Commission expires: ___________

Instructions for Completing Authorization for Disclosure/Use of Health Information

1. Print clearly and use black ink.
2. Section 1: Print name of the person whose information is to be released.
3. Section 2: Print the name and address of the person or organization authorized to receive the information and the name and address of the person authorized to receive the information. *(Note: RIDOH staff can be authorized to release and/or receive information.)*
4. Section 3: Print the reason why the information is being requested (disability claim, continuing medical care)
5. Section 4: Check all of the boxes that apply.
   - Other, *Specify*: Can include specific information identified by the client (billing, employee health)
   - **Psychotherapy notes only**: In order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes. Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
   - Specific information needed: Clearly identify the exact information to be disclosed.
   - Dates of medical service: Enter the first and last date of medical service for which records are being requested.
   - Release of sensitive information: Patient must check any/all boxes to request records related to alcohol-drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases, Medical Marijuana Program.
6. Section 5:
   - The patient, or their authorized representative, must sign and date this form in the presence of a Notary Public. Examples of authorized representatives include parent, legal guardian, power of attorney.
   - If a different expiration date is requested, specify a new date.
   - The Notary Public must sign and complete the attestation clause.

A copy of the completed Form must be given to the client.