



Office of Health Services  
Salve Regina University  
100 Ochre Point Avenue  
Newport, RI 02840  
Phone (401)341-2904 FAX (401)341-2934

### AUTHORIZATION TO RELEASE INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_

I hereby request and authorize:

\_\_\_\_\_ (staff member)

\_\_\_\_\_ To release information to \_\_\_\_\_ to receive from \_\_\_\_\_ to exchange with

Name/Organization \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

The following specific information from my records:

Dates of Treatment: \_\_\_\_\_

### INFORMATION TO BE RELEASED OR EXCHANGED:

\_\_\_\_ Complete Health Record \_\_\_\_ Mental Health Evaluation \_\_\_\_ Laboratory Tests/Radiology Reports

\_\_\_\_ Verbal Information \_\_\_\_ Progress Notes \_\_\_\_ Immunization Record

\_\_\_\_ Other \_\_\_\_\_

The purpose of this disclosure is \_\_\_\_\_

I understand that I may revoke this Authorization at any time by providing a written notice to the Office of Health Services. The revocation will not apply to information that has already been released by this authorization.

I understand that my information may be redisclosed by the authorized person/organization receiving the information and, at that point, the information may no longer be protected under the terms of this agreement.

If the patient is under 18 years of age, this release may be signed by a parent/guardian but will expire upon patient reaching majority age.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

or, Legal Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**THIS AUTHORIZATION IS EFFECTIVE FOR ONE YEAR FROM DATE OF SIGNING OR AS SPECIFIED BELOW**

\_\_\_\_\_

## **One Year Release Cover Sheet**

The attached one year authorization to release health information entitles the named person:

To request a copy of medical records after a patient visit or periodically throughout the year

To receive information over the phone regarding a prior visit by the patient

To consult with provider(s) regarding a visit by the patient

Medical records will not be automatically released upon a visit, nor will the Health Services Center automatically notify the named person of a visit by the patient.

The release is valid for only one year, unless a shorter amount of time is specified. Periods over one year are not permissible. A new release must be signed each year.

The patient may revoke or limit this authorization at any time by written notice to the Office of Health Services.

For patients under the age of 18, a parent or guardian may sign the release but the release will expire upon the patient reaching majority age.