

**Authorization to Obtain 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 Newport Hospital to obtain from:

2. \_\_\_\_\_  
 Person / Place / Institution \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone \_\_\_\_\_

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

4. Purpose for which records are being obtained:  Coordination of Care  Patient Request

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

5. Information to be obtained (check all applicable):

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 Affiliates:  Assessment  Treatment Plan  Psychiatric Evaluation  Medications

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 Brown University Health, 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 Brown University Health 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

\*Note Concerning Minors: For disclosures to persons / entities other than medical providers, the signature of a patient under 18 years who gave legal consent for testing, examination or treatment for reportable communicable disease (including HIV & venereal disease) or for alcohol and/or drug abuse treatment is required.