BROWNHealth UNIVERSITY

- **Rhode Island Hospital**
  Tel: 401-444-4040
  Fax: 401-444-7936
- **The Miriam Hospital**
  Tel: 401-793-2222
  Fax: 401-793-2477
- **Newport Hospital**
  Tel: 401-845-1153
  Fax: 401-848-6009

# LAW ENFORCEMENT OFFICIAL (LEO) INITIATED REQUEST FOR PERMITTED DISCLOSURE AND USE OF PROTECTED HEALTH CARE INFORMATION (PHI)

Verification of identity and authority of law enforcement official is required. Telephone requests require faxed cover sheet/letter, completed LEO form, and picture ID.

**REQUEST** (check one):

- ☐ Information from the medical record (fax completed LEO form to Health Information Services listed above)
- ☐ Information required urgently; verbal response needed (fax completed LEO form to clinical unit)
- ☐ To photograph deceased patient as authorized by the Next of kin (*order of authority for Next of kin is 1-Spouse or certified domestic partner 2-Adult children 3-Parent 4-Adult sibling 5-Adult grandchildren 6-Grandparent)* **OR** as authorized by the Office of the Medical Examiner.
- ☐ Other (describe): _____

As a duly authorized law enforcement official, I hereby request the release of Protected Health Information (PHI) that is necessary to carry out the responsibilities of my office.

**1) TARGET** (check one for Section 1):

☐ Suspect ☐ Fugitive ☐ Material Witness ☐ Missing Person

**2) VICTIM** (check below for Section 2)

☐ Victim

Patient Name: _____ Date of Birth: _____ and/or

Other identifying information: _____

Treatment date(s) (if known): _____

Name of Law Enforcement Official: _____ Badge #: _____

Department/Agency: _____ Phone: _____ Fax: _____

**PURPOSE** (Check **ONLY** one, Section 1 OR Section 2):

**SECTION 1 – TO ID OR LOCATE SUSPECT, FUGITIVE, MATERIAL WITNESS, MISSING PERSON**

☐ For identification or to locate a suspect, fugitive, material witness or missing person. Permitted disclosure is limited to the minimum necessary information from the following list. No other PHI may be disclosed.

(1) Name and address
(2) Date and place of birth
(3) Social Security number
(4) ABO blood type and Rh factor
(5) Type of injury
(6) Date and time of treatment
(7) Date and time of death, if applicable; and
(8) A description of any distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos, if known

**SECTION 2 – VICTIM OF CRIME (Only applicable to patients who are in the Emergency Room or admitted to the hospital at the time of the request)**

☐ For investigation of a crime in which the patient is or is suspected to be a victim of a crime (other than domestic violence), if they agree to the disclosure, or if they are unable to authorize disclosure due to medical incapacity or other emergency circumstances. Permitted disclosure is limited to the minimum necessary information to accomplish the intended purpose and the disclosure. I represent that:

(1) Such PHI is needed to determine whether a violation of law by a person other than the patient-victim has occurred; AND
(2) Such PHI is not intended to be used against the patient-victim, AND
(3) An immediate law enforcement activity that depends on the disclosure would be materially and adversely affected by waiting until the patient is able to agree to the disclosure.

*I declare the above to be true and the request is for the purpose of carrying out the responsibilities of my office. I understand that any information will be held confidential and subject to the limitations on disclosure outlined in RIGL 5-37.3-4(c):*

Signature of Law Enforcement Official | Printed Name of Law Enforcement Official | _____/_____ Date / Time