OCEAN STATE
CARDIOVASCULAR & VEIN CENTER

Patient Authorization to Disclose Protected Health Information

Patient Name:	DOB:	
Address:	City, State Zip	Telephone:

I hereby authorize Ocean State Cardiovascular and Vein Center to disclose/release the Protected Health Information specified in this request to the organization, agent or person named.

Release from: _____ **Release to:** _____

Address: _____ **Address:** _____

_____ _____

Phone: _____**Fax:**_____ **Phone:** _____ **Fax:** _____

Treatment dates: _____

Purpose: ____ Further Medical Care ___ Worker's Comp ___ Personal Use___ Legal ___Other: _____

Protected Health Information Allowed to be Included:

__ **Entire Medical Record** __**Office Notes** ___**Testing**___**Labs** ___**Other**_____

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to Ocean State Cardiovascular and Vein Center. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. 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 to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the office.
Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 1 year from the date hereof, unless a different date is specified here:_____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).
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SIGNATURE:_____ **DATE:**_____
Patient (Parent or Legal Guardian)

OFFICE USE ONLY: Attach copies of required identification.
Number of pages released: _____ Completion date: _____ Delivery method:_____
Name of individual who received request:_____
Date received:_____
Patient Medical Record Number / Account Number: _____