RHODE ISLAND DIRECT PRIMARY CARE, LLC

HEALTH MADE SIMPLE. CARE MADE PERSONAL.

Authorization for Disclosure of Health Information

Patient name: _____

Date of birth: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip**_____

I authorize the use or disclosure of the above-named individual's health information as described below, by:

Practice Name/Provider Name_____

Address:_____

_____

Phone:_____Fax:_____

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records
_____ Medical exam
_____ Immunization record
_____ Other (please specify): _____
_____ Lab results/X-ray reports
_____ Consultation reports

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

Rhode Island Direct Primary Care, LLC
1130 Ten Rod Rd, Suite E205
North Kingstown, RI 02852
Phone: 401-409-2033

Fax: 401-289-9848

***For the purpose of*:** Transfer of Care; Continuity of Care

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in **365 days.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to receive continued treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signature of participant or representative **Date**

Name of patient or representative **Description of personal representative's authority**