Internal Medicine
One Commerce Street
Lincoln, Rhode Island 02865-1149
Telephone 401-793-8500
Fax 401-793-8511

AUTHORIZATION FOR PROTECTED HEALTH INFORMATION RELEASE (*Please print all information)*

Patient's Name ______________________________
Last First MI

Address ______________________________
Street

____
City State ZIP

Date of Birth ____________ ***Telephone Number*** ____________
Month/Day/Year (Area Code) Number

I hereby consent and authorize Anchor Medical Associates to

☐ **Obtain** the record of my care ***from***:

OR ☐ **Release** the record of my care ***to***:

Purpose of this request:

☐ Transfer to new physician

☐ Share information – other health care provider

☐ Other ______________________

____
Name of Agency, Facility or Practitioner

Address ______________________________
Street City State Zip

Anchor Medical will **release** an "abstract" of my records to include 2 years of medical records and 4 years of diagnostic testing unless specified below (Anchor Medical will request all records unless specified below):

☐ All of the information **for all dates** in such records is to be released or requested

☐ Only information from __________ to __________ is to be released or requested

☐ Only the following specific information in such records is to be released or requested:

____

Anchor Medical does not provide copies of records received from another provider or institution. Please request these records directly from the original healthcare provider.

I understand that my medical record may contain information that is considered sensitive under law. My check mark(s) below indicate that I **do not** permit information of this type, if it exists, to be released or requested:

☐ Mental Health ☐ Sexually Transmitted diseases

☐ Treatment for alcohol and/or drug abuse ☐ HIV/AIDS

I understand that such records are needed for, or will be used for continuing care & coordination of care. A copy or facsimile of this form is considered valid as the original. I understand that I may be charged a fee of $15 plus $0.25 per page for the first 100 pages & $0.10 per page over 100 pages and that this fee is within the limits allowed by Rhode Island state law. I understand that if I am requesting an abstract of my records as defined above, the maximum fee I may be charged is $25.00.

Signed ______________________________ Date ____________
(Patient - age 16 years and older) Month/Day/Year

Signed ______________________________ Date ____________
(Patient's authorized representative) Month/Day/Year

Relationship ____________ Witness ____________

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that this consent may be withdrawn at any time by written request to Anchor Medical Associates at the address above and/or to the Agency, Facility or Practitioner at the address listed above.

Expiration Date ____________ (If blank, one year from date of signature)