



Authorization for Release of Information

Patient Name _____ DOB _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

1. I hereby authorize Amos House Clinic to: [] Release to [] Obtain from:

Person /Place/ Institution

Street City State Zip Code Phone

2. Dates of treatment or time period _____

3. Purpose for which disclosure is to be made: [] Coordination of Care [] Patient Request [] Legal [] Other

4. Information to be disclosed (check all applicable):

[] Medical Notes [] Psychotherapy Notes [] Labs/Imaging [] Discharge Summary

[] Other _____

5. I do not want any of the following information disclosed: [] Mental Health [] Substance Use [] Sexually Transmitted

Infections [] AIDS/HIV Status [] Other _____

6. 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.

7. 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 Amos House Clinic, its employees and my physicians from all liability arising from this disclosure of my health information.

8. I understand 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 Amos House in writing. I understand that any previously disclosed information would not be subject to my revocation request.

9. 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.