



STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. I, _____
(Print first name, last name & date of birth of the Individual for whom information is being requested)

2. I hereby authorize the following information to be released: (check all that apply)

- | | | | |
|---|---|---|---|
| ☐ Physician Orders | ☐ Social Service Records | ☐ Continuity of Care Forms | ☐ Therapy Reports |
| ☐ Physician Progress Notes | ☐ Laboratory Reports | ☐ Inter-Agency Referral(s) | ☐ Financial Records |
| ☐ Discharge Summary | ☐ History & Physical | ☐ School/Edu. Records | ☐ Billing Requests/Reports |
| ☐ Nurses' Notes | ☐ Consultation Reports | ☐ Psychology Records | ☐ Vocational Records |

☐ Other (please be specific) _____

3. I hereby authorize the following information to be released*: (check all that apply)

- | | |
|--|---|
| ☐ Substance Abuse/dependency/diagnosis/treatment/referral (42 CFR) | ☐ Mental Health/diagnosis/treatment/referral |
| ☐ HIV Test results /AIDS related information/(ARC) diagnosis and/or treatment | |
| ☐ Diagnoses and/or treatment relating to other communicable diseases | |

* This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

4. My information is to be obtained from:

5. My information is to be released to:

(Name of Organization)

(Name of Organization)

(Address)

(Address)

(City/State/Zip)

(City/State/Zip)

(Contact Name and Telephone Number)

(Contact Name and Telephone Number)

6. This authorization is for information applicable to the time period specified below:

From: _____ To: _____

7. _____
(Indicate the specific purpose or need for this release of information)

8. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal privacy regulations. The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization. I understand that I have the right to revoke this authorization in writing at anytime, and that the revocation will be effective except to the extent that BHDDH has already acted in reliance on my authorization. I understand that if this authorization has not been revoked, it will expire once the timeframe specified in Section 6 above has been met or upon my discharge from the hospital; whichever occurs first. **My instructions to revoke my authorization should be directed to:**

(Name and address of BHDDH Records person responsible for this request)

9. Signature of individual: _____ Date: _____

10. Signature of authorized representative _____ Relationship: _____

Print Name: _____ Date: _____

For Office Use Only: Information Released: Y N Date of release: _____
Staff Person Releasing Information: _____

**INSTRUCTIONS FOR COMPLETING THE BHDDH
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION FORM**

Please write legibly, in ink

- Section 1. Print the name and date of birth of the individual whose information is to be released.
- Section 2. Check all of the boxes that apply: Write-in information where indicated (e.g., Physical, Occupational, Respiratory...)
- Section 3. Check the box(s) next to the type(s) of sensitive information if you do not want this sensitive information to be released.
- Section 4. Print the name and address of the organization authorized to release the information, and the name and telephone number of the contact person from the organization that will be releasing the information.
- Section 5. Print the name and address of the organization authorized to receive the information, and the name and telephone number of the contact person from the organization that will be receiving the information.
- Section 6. Indicate the specific month and year that reflect the beginning and ending dates of service associated with the information being released or a start event and an expiration event (e.g., 'start of treatment' to 'end of treatment'). **Please do not use an unspecific description such as "All Dates of Service."**
- Section 7. Indicate the reason why the information is needed.
- Section 8. Print the name and address of the individual at MHRH responsible for receiving an individual's instructions to revoke the authorization.
- Section 9. Dated signature of the individual whose information is to be released.
- Section 10. Signature and printed name of the authorized representative with a description of their relationship to the individual whose information is to be released.

Note: An authorized representative is required only if the individual whose information is to be released is incapable of authorizing the release of confidential information.