Lifespan

Gateway Healthcare
A Lifespan Partner
Health Information Department
1 Virginia Avenue, suite 200
Providence, R.I. 02905
Tel: 401-667-6567; Fax: 401-444-2365

Authorization to Use or Disclose Protected Health Information

(This form must be completed in full before signing)

Patient Name_____ DOB_____ Phone _____

Address _____
Street City State ZIP

1. I hereby authorize Gateway Healthcare to: ☐ Release to ☐ Obtain from ☐ Verbal Communication

2. _____
Person / Place / Institution

_____
Street City State ZIP Phone

3. *Dates of treatment or time period* _____

4. *Purpose for which disclosure is to be made:* ☐ *Coordination of Care* ☐ *Patient Request* ☐ *Legal.*

Other (please specify):_____

5. Record Format-please check one: □ Paper □ CD disc.

6. Information to be disclosed (check all applicable): *There may be a fee associated with this request.*

☐ Emergency Dept. Record ☐ Operative/Path Report ☐ Lab/X-ray Reports ☐ Other Diagnostic Testing

☐ Clinic/Office Visit ☐ Consultation / Evaluation ☐ After Visit Summary

☐Abstract* ☐Discharge Summary ☐Other_____

*Abstract includes: Facesheet, ED Record, H & P, D/C Summary, Consult, Operative report, Pathology report, test results, PT/OT/ ST

For Behavioral Health: ☐Assessment ☐Treatment Plan ☐Psychiatric Evaluation ☐Medications ☐Progress Notes

7. I do **not** want the following information disclosed: ☐ mental health ☐ alcohol/drug use/test

☐sexual abuse ☐sexually transmitted infections ☐AIDS/HIV test results

8. 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.

9. 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 Gateway Healthcare, its employees and my physicians from all liability arising from this disclosure of my health information.

10. It is my understanding that 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 Gateway Healthcare in writing. I understand that any previously disclosed information would not be subject to my revocation request.

11. 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

Rev: 1/ 2016, GW revised 7/2016, GW revised 8/2017, GW REV. 10/01/2020

□ Mail Out or □ File Only