Lifespan Physician Group, Inc.
Obstetrics & Gynecology
c/o Health Operations Administrator – HIS Dept.
164 Summit Avenue
Providence, RI 02906
Ph: 401-793-2570 Fax: 401-793-5131
All OB records should be faxed to 401-331-6247

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 Lifespan Physician Group, Inc. Obstetrics & Gynecology to: ☐ Obtain from ☐ Release to

2. _____ _____
Person /Place/Institution Phone Number

_____ _____
Street City State ZIP Fax Number

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 ☐data storage device

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

☐Other_____

For Behavioral Health Affiliates: ☐Assessment ☐Treatment Plan ☐Psychiatric Evaluation ☐ Medications

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 Lifespan, 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 Lifespan 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

*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.