Salve Regina University
Health Services
100 Ochre Point Avenue
Newport, Rhode Island 02840
(401) 341-2904 FAX (401) 341-2934

Authorization for Disclosure of Health Information

(1) I hereby authorize_____to disclose the following information from the health records of:

Patient Name: _____ Date of Birth_____
Home Address: _____ Home Telephone_____
_____
College Address:_____ College Telephone_____

Covering the period(s) of healthcare:
From (date)_____ To (date)_____
From (date)_____ To (date)_____

(2) Information to disclosed:

__ Complete health record(s) __ Progress Notes
__ Health Report Form __ Laboratory Tests
__ Immunizations __ X-Ray Reports
__ Other (please specify)_____

Please indicate if you want the following information released if applicable.

Yes__ No__ Acquired (Immunodeficiency Syndrome AIDS) or infection with HIV (Human Immunodeficiency Virus)
Yes__ No__ psychiatric conditions and care
Yes__ No__ pregnancy
Yes__ No__ sexually transmitted disease treatment

(3) This information is to be disclosed to_____for the purpose of _____

(4) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____

(5) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed:_____
(Patient) (Date)

_____

or (Legal Representative) (Relationship to Patient) (Date)