South County Internal Medicine
481 Kingstown Rd
Wakefield, RI 02879 401-789-0283

Authorization for Use and
Disclosure of Medical Information

Patient Information: Print Name: Date of Birth
SS#: (Last 4 Digits): _____ Maiden or Prior Last Name: _____ Phone #:
Release my Healthcare Information **FROM**:
Name of Facility/Provider:
_____
Address: _____
City/State/Zip: _____
Phone Number: _____
Fax Number: _____

Release my Healthcare Information **TO**:
Name of designated recipient:
South County Internal Medicine
481 Kingstown Road
Wakefield, RI 02879
Phone Number: 401-789-0283
Fax Number: 401-789-0314

Information to be Released Format: Paper _ Electronic _
_ Records from _____ to _____ only
_ The most recent 2 years of pertinent information (chart notes, labs, ultrasounds, special tests, etc.)
_ Complete Medical Record
_ Other (Specify): _____ _ Billing Records from _____ to _____

Purpose of Request:
_ Continuing Care _ Workman's Comp.
_ Personal use _ Disability Determination
_ Other (Specify): _____

Fees for Copying Medical Records
The following fees will apply:
The actual retrieval fee for medical records stored off-site: $_____.
The base preparation fee of $_____
A charge of $_____ per photocopied page, and the actual cost of postage.
These total fees must be paid before your medical records can be released: $_____.

My Rights
I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present to the office where my information is being released. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
I understand that authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I many inspect or receive copies of the information to be used or disclosed, as provided in the Code of Federal Regulations (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Patient Authorization
I understand that I many be charged the fees shown above for the copying of my medical records. I authorize the release of my medical records (including medical information related to the diagnosis or treatment for HIV testing, drug and alcohol, or a psychiatric condition) specified above.
Signature: _____ Date: _____
(Patient, Guardian*, Authorized Representative*)
*Must provide documentation to prove authority to sign on behalf of the patient

THIS AUTHORIZATION WILL EXPIRE ONE YEAR (12 MONTHS) FROM THE DATE SIGNED