AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

(Please Print Clearly in Blue or Black Ink Only)

Section 1: I, _____, hereby authorize _____ to use and/or disclose the Confidential and Protected Health Information ("PHI") of the patient described below. I understand that information used or disclosed pursuant to this authorization could be subject to disclosure by the recipient and its confidentiality may no longer be protected by federal or state law.

Section 2: Patient name: _____ Date of Birth: _____

Address: _____
Street City State Zip

I am (check one): ☐ The Patient or ☐ The Patient's Heir at Law and/or Personal Representative by virtue of:

_____

_____

Section 3: Information may be disclosed to (the "Receiving Party"):

_____
Name

_____
Address

_____
City State Zip

Section 4: The PHI that may be disclosed and/or used is:

☐ All PHI

☐ **Only** Psychotherapy Notes

☐ **Only** the following PHI: _____

_____

_____

_____

_____

Section 5: I give specific permission for the following sensitive information regarding the patient to be used and/or disclosed (Check any/all boxes that apply):

☐Alcohol and/or Drug Abuse Treatment ☐HIV/AIDS-Related Testing & Treatment
☐Sexually Transmitted Diseases ☐Medical Marijuana Program(s)

Section 6: The purpose or need for the release of this information is: _____

_____

Section 7: This authorization shall remain in effect until:_____
[Expiration Date/Event]

Notice of Automatic Revocation in Certain Insurance Circumstances: Pursuant to R.I. Gen. Laws §5-37.3-4(d)(3), when an authorization is executed in connection with an application for a Life or health insurance policy, the authorization will expire two (2) years from the issue date of the insurance policy. When an authorization is signed in connection with a claim for benefits under any insurance policy, the authorization shall be valid during the pendency of that claim.

Section 8: The individual and/or entity receiving the information under this authorization ☐ will / ☐ will not receive direct or indirect remuneration in exchange for disclosing and/or using any information under this authorization.

Section 9: I understand that I may revoke this authorization in writing at any time to the City of Pawtucket, mailed and/or delivered to _____, except to the extent that any party has taken action in reliance on the authorization. Any information disclosed pursuant to this authorization, as well as any information disclosed to other parties under this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 C.F.R. Part 164), the Rhode Island Confidentiality of Health Care Communications and Information Act (R.I. Gen. Laws § 5-37.3-1 *et seq.*), or the Privacy Act of 1974 (5 U.S.C. § 522(a)). Any information released or received as a result of this authorization shall not be further relayed in any way to any person or organization outside the City of Pawtucket without additional written consent from the Patient or the Patient's Personal Representative.

_____
Signature of Records Requestor *Date*

_____
Signature of Patient/ Personal Representative *Date*

State of Rhode Island, County of_____
On this _____ day of _____, 20___, before me personally appeared _____ personally know to the notary or proved to the notary through satisfactory evidence of identification, to be the person whose name is signed on the preceding or attached document in my presence.

Signature of Notary Public: _____
Printed name, Notary Public: _____Commission Expires:_____

Instructions for Completing Authorization for Disclosure/Use of Confidential and Protected Health Information

1. Please clearly print your name and the name of the individual/entity who will be authorized to disclose or use Confidential and Protected Health Information ("PHI").

2. Please provide the name, date of birth, and address of the patient whose information is to be used and/or disclosed. If you are not the patient, please provide the source of the authority under which you are making this authorization. PHI may only be disclosed to the patient themselves or a person who qualifies as an authorized and/or personal representative under both the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 C.F.R. Part 164) and the Rhode Island Confidentiality of Health Care Communications and Information Act (R.I. Gen. Laws § 5-37.3-1 *et seq.*)

3. Please provide the legal name and address of the party that is to receive the information disclosed and/or used pursuant to this authorization.

4. Please state specifically what PHI you are authorizing the disclosure and/or use of. If you are authorizing the use and/or disclosure of Psychotherapy Notes and other PHI, you **must complete two separate authorizations.** One authorization for the disclosure and/or use of the Psychotherapy Notes and a separate authorization for the disclosure and/or use of any other PHI. Federal law does not allow for an authorization for the disclosure/use of Psychotherapy Notes to be combined with any other form of authorization.

5. Certain portions of PHI are considered more sensitive than others given the personal nature of the information. Please fill in the check box for each individual piece of sensitive information for which you are authorizing the use and/or disclosure.

6. Please give the specific reasons and/or purposes for which the patient's PHI is being disclosed. If you are the patient whose information will be used and/or disclosed pursuant to this authorization, the statement "at the request of the patient" is sufficient if you, as the patient, are the individual who initiated this authorization.

7. Please list a specific date on which this authorization will expire. You may also list a specific event the occurrence of which will cause this authorization to expire.

8. If the authorization is to permit the use or disclosure of PHI for purpose of marketing or the sale of PHI, and the Receiving Party will receive payment or other remuneration for the PHI, whether directly or indirectly, the authorization must state as such.

9. PHI cannot be disclosed and/or used until (1) every single section of the above form is filled out, (2) the patient or personal representative signs the authorization, (3) the patient has their signature notarized, and (4) the receiving party signs the authorization. **The patient or personal representative making this authorization has a statutory right to receive a copy of the completed authorization.**