CITY OF CENTRAL FALLS
LAW DEPARTMENT

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MEDICAL AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
(Release of Medical Records)

I, _____, (DOB: / /), do hereby authorize the City of Central Falls to disclose the confidential health information of _____ to _____ for the following purpose(s):
_____
_____

By initialing in the spaces below, I specifically authorize the disclosure of the following health information and records:

_____ Entire medical record (all information)
_____ Billing record
_____ Records developed between _____ to _____ (insert start and end dates)

*** If the information to be disclosed contains any of the following types of information or records listed below, additional laws relating to the disclosure of this information may apply. I agree the following categories must be initialed to be included in this authorization to release information.

_____ *** HIV/AIDS related information/records
_____ *** Mental health information/records
_____ *** Genetic testing information/records
_____ *** Drug/alcohol diagnosis, treatment and/or referral information. (Federal law prohibits the re-disclosure of this information. Federal law requires that a description of the kind and how much information be included: _____
_____ Psychotherapy notes [if authorization is for the disclosure of psychotherapy notes, it cannot be combined with any other authorization.

Except to the extent that action has been taken in reliance of this authorization, I understand that I may revoke the authorization at any time by giving written notice to this provider. Unless revoked earlier, this authorization will terminate on _____.

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, enrollment or eligibility for benefits. I may inspect or copy any information disclosed under this authorization. I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I understand that the person(s) I am authorizing to disclose my information may receive compensation for doing so.

_____ _____
(Signature of Individual or Legal Representative) (Date)

_____ _____
(Name of Individual or Legal Representative) (Relationship to Individual)