Ortho Rhode Island

Authorization of Disclosure of Medical Records

Patient's Full Name	**Patient's Social Security Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize **Ortho RI** to disclose protected health information about me as described below:

1. The following person (or class of persons) may receive disclosure of protected health information about me:

   Name

   Address

   City, State, Zip Code

   Phone Number **Fax Number**

2. The specific information that should be disclosed is (please give dates of service if possible):

   ____

   ____

   INITIAL HERE, OTHERWISE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION *______ ________________
   NO, **DO NOT** DISCLOSE THIS INFORMATION * ___ ___________________

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying **Ortho RI** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for ____.
6. This authorization expires on _____, 20 , OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: ________________________________.

Signature of Patient or Guarantor **Date of Signature**