Ortho Rhode Island
Caring for your every move.

Authorization of Use and Disclosure of PHI

Patient Full Name: ______________________ Patient's Date of Birth: ______________________

Address: ______________________ Patient's Telephone Number: ______________________

City, State, Zip Code: ______________________ ORI Physician Name(s): ______________________

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: ______________________

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

   ____

   ____

   ____

   SIGN 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 ______________________ 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 in one year, unless otherwise stated here: ______________________, 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:

   ______________________.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. Records will be mailed along with an invoice. We contract with Sharecare for records management.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**
if applicable – **Signature of Guardian* or** Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the individual or other signator.

Official Use Only

Received	*Processed By*	*Log #*