Ortho Rhode Island
Caring for your every move.

Authorization of Use and Request of PHI

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

Address: _____ Patient's Telephone Number: _____

City, State, Zip Code: _____ ORI Physician: _____

Email: _____ Fax #: _____

I request that my records be ☐ emailed ☐ mailed ☐ faxed

I understand that emailed record will be encrypted and that there are file size limits. If file is too large it will be mailed.

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 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* _____

I understand that the information used or disclosed may be subject to re-disclosure by Ortho RI and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying OrthoRI 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.

My purpose / use of the information is for continuation of care.

This authorization expires in one year, unless otherwise stated here: _____ , OR upon occurrence of the following event that relates to me or to the purposed of the intended use or disclosure of information about me:

_____ .

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

	Signature of Individual*	**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**