

**RHODE ISLAND COLLEGE
STUDENT HEALTH SERVICES
600 MOUNT PLEASANT AVENUE
PROVIDENCE, RI 02908
PHONE: 401-456-8055 FAX: 401-456-8890**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Copies of your medical record cannot be released until this form is completed, signed by the student or legal guardian(if under age 18).

STEP 1: Information about you:

PLEASE PRINT!

NAME: _____ OTHER NAMES (eg, maiden): _____
 Last First MI

SS#: _____ DATE OF BIRTH: _____ PHONE NUMBER: _____

COLLEGE STATUS: _____ current student _____ graduate (year _____) _____ inactive (years attended _____)

STEP 2: Method of release:

_____ PERSONAL PICKUP WITH A PHOTO ID _____ PHOTOCOPIES SENT BY MAIL
_____ TELEPHONE / VERBAL _____ PERMISSION TO FAX

STEP 3: To whom do you wish to release your records to or obtain your records from?

PLEASE PRINT!

TO/FROM (NAME OF PERSON/FACILITY, ADDRESS, PHONE OR FAX NUMBER AS APPLICABLE):

RELEASE THE FOLLOWING INFORMATION:

_____ ENTIRE HEALTH RECORD _____ IMMUNIZATION INFORMATION ONLY _____ OTHER: _____
_____ SPECIFIC DATES OF TREATMENT: FROM _____ TO _____

FOR THE PURPOSE OF: _____ CONTINUITY OF CARE _____ WORK/SCHOOL _____ OTHER: _____

STEP 4: Authorization and signature:

I hereby authorize _____ to release the records as described above. This authorization is valid for 60 days and may be revoked at any time in writing prior to the expiration date. I do not give permission for any other use or re-disclosure of this information.

Patient Signature

Guardian Signature (if under 18)

Date

STEP 5: Release of Sensitive Information:

I hereby authorize _____ to release all information in such records, including mental illness, alcoholism, drug abuse, sexually transmitted disease, or HIV test, if any.

Patient Signature

Guardian Signature (if under 18)

Date