CITY OF PROVIDENCE

Brett P. Smiley, Mayor

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name_____ Phone Number _____

Date of Birth_____ Medical Records # _____

Address _____

☐ I hereby authorize City of Providence to disclose any and all of my health information to:

_____.

☐ I hereby authorize _____ to disclose any and all of my health information to City of Providence.

1. Information to be disclosed:
   _____
   _____
   _____
   _____
   _____

2. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, City of Providence will release such information about me if it exists.

   ☐ HIV/AIDS infection
   ☐ Sexually transmitted diseases
   ☐ Genetic information
   ☐ Treatment for alcohol and/or drug abuse
   ☐ Mental Health

3. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

4. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying City of Providence. I understand that any previously disclosed information would not be subject to my revocation

request and that once the health information is released by City of Providence, it may be re-released by the recipient of the information and no longer protected by federal law.

5. 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 or my eligibility for benefits, unless otherwise described in the space provided here

_____

_____

This form must be fully complete before signing.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____

Print Patient's Name

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient