CENTER FOR SPORTS MEDICINE

MUSCULOSKELETAL AND CONCUSSION CARE

Administrative Office:
125 Whipple Street, 3rd Floor
Providence, RI 02908
Fax: 401-854-2519

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient: _____ Date of Birth: _____
Address: _____ Telephone: _____
_____
_____

We will send
TO:
_____
_____
_____

FROM: Center for Sports Medicine
125 Whipple Street, 3rd Floor
Providence, RI 02908

( ) Consultation notes
( ) Laboratory studies
( ) X-ray reports
( ) Other: Discussion of concussion management and academic restrictions

This authorization includes allowing the transfer of information regarding:
( ) AIDS (Acquired Immunodeficiency Syndrome)
( ) HIV (Human Immunodeficiency Syndrome)
( ) Psychiatric Disorder
( ) History of treatment for drug or alcohol abuse ( ) Other _____
I understand that this authorization may be revoked at any time prior to an actual release of records made in good faith that occurred in reliance on this authorization. This authorization will automatically expire 90 days from the date below.

THIS AUTHORIZATION DOES NOT ALLOW AN AGENCY RECEIVING RECORDS FROM FURTHER DISTRIBUTING THEM WITHOUT ADDITIONAL WRITTEN CONSENT OF THE PATIENT.

Signed: _____ Date: _____
Patient/Legal Guardian

Witness: _____