



Rhode Island HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

I hereby authorize **Seaside Primary Care / Dr. Debra Furtado DNP, APRN, FNP-BC**
27 East Ave. Westerly, RI 02891 Phone # 401-500-0996 Fax # (866) 559-1153

To release my records to: _____

1. Disclose the protected health information described below to:
2. Authorization for Release of Information.
Covering the period of health care from _____ to _____ **OR** send **ALL** past, present and future periods. **(Circle ALL or write in dates)**
 - a. Yes/No___ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable disease, HIV or AIDS and treatment of alcohol/drug abuse)

OR
 - b. Yes/ No___ I hereby **authorize the release of my complete health record except** for the following
 - i. ___Mental health records
 - ii. ___Communicable diseases records like (HIV and AIDS)
 - iii. ___Alcohol/drug abuse treatment
 - iv. ___Other (please specify): _____
3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. This authorization shall be in force and effect until I decide otherwise.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient