THE UNIVERSITY OF RHODE ISLAND
DIVISION OF STUDENT AFFAIRS

AUTHORIZATION TO RELEASE OR REQUEST MEDICAL INFORMATION

Health Information Management Department
Ph: 401-874-4763 Fax: 401-874-9110
Email: health@uri.edu

THINK BIG WE DO

DR. PAULINE B. WOOD HEALTH SERVICES
6 Butterfield Road, Potter Building, Kingston, RI 02881 USA p: 401.874.2246 f: 401.874.2586 http://health.uri.edu

Patient's Name: _____ Date of Birth: _____

Address: _____

Patient's ID#: _____ Phone: _____

Permission is hereby given for URI Health Services to

☐ **RELEASE TO** ***and/or*** ☐ **REQUEST FROM**

Name: _____ Phone: _____

Street: _____ Fax: _____

City: _____ State: _____ Zip: _____

MEDICAL INFORMATION

Information and dates to be disclosed: From (date) _____ To (date) _____

☐ Provider/nursing notes ☐ X-ray reports ☐ Physical exam
☐ Laboratory tests ☐ Complete health record ☐ _____ OTHER
☐ Women's Care: ☐ notes ☐ lab work
☐ Permission for coordination of services with URI Counseling Center

PURPOSE FOR RELEASE OF INFORMATION: _____ PHYSICIAN, LAWYER, INSURANCE, OTHER

SPECIFIC CONSENT IS REQUIRED TO EXCLUDE THIS INFORMATION
(Please initial below if you **DO NOT** authorize disclosure of the following information)

Sexual assault: _____ HIV testing results: _____

Mental health: _____ Sexually transmitted disease: _____

Drug/Alcohol: _____ Pregnancy: _____

Other: _____

THIS AUTHORIZATION IS VALID FOR 90 DAYS
I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release URI Health Services from any liability or legal responsibility in connection with the release of the above information.

INFORMATION TRANSFER:

☐ Mail directly to URI Health Services, Attention Health Information Management

☐ For pickup ☐ Mail to patient ☐ Mail to addressee ☐ Verbal ☐ Other

RISKS AND CONSEQUENCES OF FAXING MEDICAL RECORDS ACCEPTED ☐

_____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE