University of Rhode Island
HEALTH SERVICES

Medical Records Department
401-874-4753/Fax 401-874-9110

6 Butterfield Road
Kingston, RI 02881

AUTHORIZATION TO RELEASE OR REQUEST MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____

Patient's SS/ID#: _____ Phone: _____

Permission is hereby given for URI Health Services to

☐ **RELEASE TO** ☐ **REQUEST FROM**

Name: _____ Phone: _____

Street: _____ Fax: _____

City: _____ State: _____ Zip: _____

MEDICAL INFORMATION

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

☐ Physician/nursing notes ☐ X-ray reports ☐ History & physical exam

☐ Laboratory tests ☐ Complete health record ☐ _____
OTHER

☐ Women's Clinic ___ notes ___ lab work

☐ Permission for coordination of services from URI Counseling Center

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

SPECIFIC CONSENT IS REQUIRED TO RELEASE THIS INFORMATION
(Please initial below if you wish to disclose the following information)

Sexual assault: _____ HIV/AIDS: _____

Mental health: _____ HIV testing results: _____

Drug/Alcohol: _____ Sexually transmitted disease: _____

Other: _____ Pregnancy: _____

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.

RISKS AND CONSEQUENCES OF FAXING MEDICAL RECORDS ACCEPTED ☐

TYPE OF REQUEST:

☐ Mail directly to URI Health Services, Attention Medical Records

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

_____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE

FOR URI HEALTH SERVICES USE ONLY:

Date _____ **Mailed** ☐ **Faxed** ☐ **Date Received:** _____ **By:** _____ **Reviewed by:** _____ **MR#:** _____ **Provider:** _____

23925