Yale NewHaven Health
Westerly Hospital

Authorization for Release of Information

Patient Legal Name: _____ _____ ___ _____ _____
(Last) (First) M.I. Preferred Name (Maiden/Other Name)

Date of Birth: _____ **Phone:** _____ **Email:** _____

Patient's Address: _____
(po box # or street, city, state, zip code)

This information is to be used for purpose of: ☐ Personal use ☐ Continuing care ☐ Legal ☐ Disability ☐ Workers Comp

☑ Insurance Eligibility/Benefits ☐ Social Security Claim ☐ Veterans Benefits ☐ Other _____

Release information from my medical record to:

Name: _____ Phone: _____

Address: _____
Street City State Zip Code

Delivery Method: (Choose one only)

☐ MyChart patient portal (Must have active account. To activate your account go to mychart.ynhhs.com)

☐ Mail ☐ Fax (Please enter the fax number): _____

☐ Secure Email: _____ ☐ Pick Up/Hand Carry Format: ☐ CD-ROM

Information to be sent:

Date of Service(s): _____ **Or Date Range From:** _____ **To:** _____

Medical Information Requested:

☐ Hospital Admission Abstract (Includes: History & Physical Exam, Discharge Summary, Consult Report, ED Report, Operative Report, Pathology Report, Lab Results, Radiology Report)

☐ Outpatient Visit Notes	☐ History & Physical Exam/HP	☐ Stress Test	☐ Consult Report
☐ Discharge Summary/DS	☐ Lab Results	☐ Echocardiogram/EKG	☐ Immunization Record
☐ Emergency Visits/ED	☐ Radiology Report	☐ Pulmonary Function Test	☐ Medication List
☐ Operative/Procedure Report	☐ Pathology Report	☐ PT/OT/Speech Notes	☐ Other: _____

☐ Complete Medical Record *(Excludes data collection flowsheets unless specifically requested).* ☐ Include Flowsheets

Items requested below will be sent separate from medical records:

☐ Radiology Images: Please specify date and type of test: _____

☐ Itemized Bill: Please specify date of service: _____

SENSITIVE INFORMATION: All information selected on page 1 will be disclosed with this authorization unless specifically requested to be excluded as indicated below. Please do NOT include the following information:

☐ HIV ☐ Behavioral Health/Psychiatric ☐ Substance Abuse (which includes Alcohol & Drug Abuse)
☐ Termination of Pregnancy ☐ Sexually Transmitted Disease ☐ Genetic Testing
☐ Other: _____

I understand that:

- This authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting in writing Westerly Hospital Release of Information Services. Cancellation of the authorization will not apply to information that has already been released based on this authorization.
- The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization or by federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- That this authorization is voluntary and my treatment by Westerly Hospital is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. If I do not sign this form, payment for this care will only be affected if my health care insurer is requesting this information and is permitted to require this authorization.
- On request, I may review or have copied the information described on this form if I ask for it. There may be a charge for copies in accordance with Rhode Island law.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under Rhode Island state law. If HIV, Behavioral Health, Drug/Alcohol information is included, the minor must sign as described above.

***** Medical records containing protected information under applicable federal or state laws must also be authorized by a minor when age 13 or older (e.g. HIV, substance abuse (including alcohol & drug abuse), termination of pregnancy, and/or sexually transmitted disease). For behavioral health, the patient if a minor age 16 or older is also required to authorize release of medical records.**

Return completed authorization by mail, fax, or email as designated below. Do not send medical records to this address.

Mailing Address: **Westerly Hospital**
Health Information Management
Release of Information Services
25 Wells Street
Westerly, RI 02891

Westerly Hospital Fax Number: 401-348-3774 **Email to: releaseofinfo@westerlyhospital.org**

Routine requests for medical records are generally processed within 10 business days. To contact a Customer Service Representative, please call 401-348-3262.

Printed Name: _____ Date: _____

_____
Signature of Patient or Authorized Representative
***must provide proof of authority (except parent of a minor)*

Please check relationship to patient

☐ Self ☐ Parent ☐ Legal Guardian ☐ Executor/Administrator of Estate ☐ Healthcare Representative ☐ Conservator
☐ Other Authorized Legal Representative _____ (indicate)

Printed Name of Minor (when applicable)***	Signature of Minor (when applicable)***	Date