



- 2 Dudley Street, Providence, RI 02905. Tel: 401-272-1800/Fax: 401-751-5124
- 195 Collyer Street, Providence, RI 02904. Tel: 401-793-5140/Fax: 401-793-5171
- 208 Collyer Street, Providence, RI 02904. Tel: 401-725-4888/Fax: 401-725-3336
- 100 Highland Avenue, Providence, RI 02906. Tel: 401-553-8360/Fax 401-421-7721
- 11 Friendship Street, Newport, RI, 02840. Tel: 401-619-3930/Fax: 401-849-0410
- 1407 South County Trail, Building 4 Suite 423, East Greenwich, RI 02818

Internal Use
Patient ID: _____

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated.

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information: Brown Surgical Associates

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone/Fax: _____ / _____

Email *: _____

* **Secure Communication** - Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- Entire patient record; **or**, check **only** those items of the record to be disclosed:
- | | |
|--|--|
| <input type="checkbox"/> office notes | <input type="checkbox"/> nursing home, home health, hospice, and other physician records |
| <input type="checkbox"/> lab results, pathology reports | <input type="checkbox"/> record of HIV and communicable disease testing |
| <input type="checkbox"/> x-rays | <input type="checkbox"/> record of mental health or substance abuse treatment |
| <input type="checkbox"/> financial history report (previous 3 years only). | <input type="checkbox"/> Only send the following: _____ |

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

Patient Request Other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

patient or authorized representative signature

date

You have the right to receive a copy of signed authorizations upon request.

