



GREENWICH BAY MEDICINE &
BLACKSTONE VALLEY MEDICINE
DIVISIONS OF



Consent for Disclosure of Confidential Health Information

Name (Last, First, MI): _____ DOB: _____
Address: _____ Phone: _____

Information to be Disclosed:

Dates of Treatment or time period: _____

<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Lab reports
<input type="checkbox"/> History & Physicals	<input type="checkbox"/> Urgent care / ER reports
<input type="checkbox"/> Consult Notes	<input type="checkbox"/> Hospital Admission / Discharge reports
<input type="checkbox"/> Operative Reports	

Purpose of Request:

<input type="checkbox"/> Continuation of care	<input type="checkbox"/> Attorney / Legal	<input type="checkbox"/> Insurance	<input type="checkbox"/> Social Service / Disability
<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Personal	<input type="checkbox"/> Other: _____	

Please **DO NOT** disclose ANY of the following information:

_____ Information related to confidential communications with psychotherapist, counselor or social worker	_____ Information about genetic testing
_____ Information about HIV / AIDS	_____ Information about venereal disease
_____ Information about substance abuse	_____ Mammography records
_____ Information about abortion	
_____ Information about family planning services	

Please release information FROM:

Please release information TO:

MDRI Greenwich Bay Medicine
1407 S. County Trail, Ste. 431
East Greenwich, RI 02818
Ph: (401) 398-0288 / Fax: (401) 471-7365

Please mail or fax records. Disc not accepted.

This Authorization will remain in effect until withdrawn, OR:

_____ From the date below until the _____ Day of _____, 20_____.
_____ Until the following event occurs: _____
_____ Other: _____

By signing below, I voluntarily authorize the use and / or disclosure of the information detailed above

Signature of Patient

Date

If the patient is an emancipated minor, or physically / mentally incapacitated the following signature will stand as a valid authorization