RHODE ISLAND COLLEGE
STUDENT HEALTH SERVICES
600 MOUNT PLEASANT AVENUE
PROVIDENCE, RI 02908
PHONE: 401-456-8055 FAX: 401-456-8890

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete form thoroughly. Copies of your medical record cannot be released until this form is completed, signed by the student or legal guardian (if under age 18).

STEP 1: Information about you: **PLEASE PRINT!**

NAME: _____ OTHER NAMES (eg, maiden): _____
Last First MI

Student ID #: _____ DATE OF BIRTH: _____ PHONE NUMBER: _____

COLLEGE STATUS: _____current student _____graduate (year_____) _____inactive (years attended _____)

STEP 2: Method of release:

_____ PERSONAL PICKUP WITH A PHOTO ID _____ PHOTOCOPIES SENT BY MAIL

_____ TELEPHONE / VERBAL _____ PERMISSION TO FAX

STEP 3:
Release your records to:
(NAME OF PERSON/FACILITY, ADDRESS, PHONE OR FAX NUMBER AS APPLICABLE):

_____

_____

OR
Obtain record from:

_____

_____

RELEASE THE FOLLOWING INFORMATION:

_____ ENTIRE HEALTH RECORD _____ IMMUNIZATION INFORMATION ONLY _____ OTHER: _____

_____ SPECIFIC DATES OF TREATMENT: FROM _____ TO _____

STEP 4: Authorization and signature:

I hereby authorize _____ to release the records as described above. This authorization is valid for 60 days and may be revoked at any time in writing prior to the expiration date. I do not give permission for any other use or re-disclosure of this information.

_____ _____ _____
Patient Signature Guardian Signature (if under 18) Date

STEP 5: Release of Sensitive Information:

I hereby authorize _____ to release all information in such records, including **mental illness, alcoholism, drug abuse, sexually transmitted infections, or HIV test, if any.**

_____ _____ _____
Patient Signature Guardian Signature (if under 18) Date