RHODE ISLAND DEPARTMENT OF CORRECTIONS
Health Information Services
PO Box 8249 Telephone: 401-462-3880
Cranston, Rhode Island 02920 Fax: 401-462-2683

Authorization to Request/Release Health Care Information

Patient: ________________________________ DOB: ___________ Inmate ID# __________
Print Name

I hereby authorize: ____

To disclose to: ________________________________ Attention: ____________________

The following information (be specific):

[ ] History and Physical [ ] Lab Results [ ] X-ray Reports/EKGs
[ ] Contact Notes/Physician Orders [ ] Consults [ ] Medication Records
[ ] HIV Test/AIDS related information (RIGL 23-6-17) [ ] Other ____________________
[ ] Drug/Alcohol abuse information (42 CFR Part 2)

Covering the period from: _________________ to: __________________

Purpose of Disclosure: ____

I have read carefully and understand the above statements and voluntarily consent to disclosure of the above information (including alcohol and drug abuse records and/or HIV test, if relevant), to those persons/agencies named above. Information released with this authorization shall not be sold, transferred, or in any way given to any other person without first obtaining my additional written authorization. The Department of Corrections is not responsible for unauthorized re-disclosure by the designated recipient.

This authorization will have a duration of no longer than 90 days after the date on this form. I understand that I may revoke my permission at any time EXCEPT to the extent that action has been taken in reliance on it. If I wish to revoke this authorization, I will forward a request IN WRITING to the Medical Records Administrator at the above address.

Signature_________________________________ Date: ___________________

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If you are currently an inmate and want a copy of your RI DOC medical record – you must sign this voucher as an Authorization for payment from your inmate account

(Note: Unsigned vouchers will not processed – you will not receive your copies)

Fee Schedule: $0.25 per page for the first one hundred (100) pages
0.10 per page for every page over one hundred (100)

Signature_______________________________ Date: _____________________

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Please note: As a health care provider, there are no funds available for photocopies received from community providers. Please call the number above prior to forwarding copies if you there is a cost associated with this service. Thank you.

Original – Medical Record Yellow – attach to copies
Pink – Inmate Accounts Gold – Patient (retain this copy for your personal use)
Revised form: # 027 - 6/14/01; revised 12/04