Hematology & Oncology
RHODE ISLAND

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ Date of Birth _____

Authorize: Hematology & Oncology Associates of Rhode Island, Inc.
1220 Pontiac Avenue, Suite 101
Cranston, RI 02920
(401) 943-4660

Check One: ☐ Obtain From ☐ Furnish To ☐ Furnish To & Obtain From
NAME _____
ADDRESS _____

Information pertaining to my identity, prognosis, diagnosis or treatment.
Information to be released includes:

☐ Discharge Summary
☐ Progress Notes
☐ History/Physical
☐ Other (Please be Specific): _____
_____
_____

☐ Psychiatric Exam/Treatment Plan
☐ Psychological Tests
☐ Laboratory Data

For Date(s) of Service: _____

I understand that my records are protected under Rhode Island General Law and cannot be disclosed without my written consent except otherwise specifically provided by law. Further, I understand that if records involve alcohol or drug abuse, they are also protected under federal regulation 42CFR, Confidentiality of Alcohol and Drug Abuse.

I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclose the above information and/or medical records (including alcohol and drug abuse records of my condition, if relevant) to those persons/agencies named above.

I further release Hematology & Oncology Associates of Rhode Island, Inc., employees from any liability arising from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law.

This authorization will have duration of consent no longer than 90 days after the date of this form. I understand that I may revoke my consent at any time, except to the extent that action has been taken in reliance on it.

_____ _____
Signature of Patient/Legal Guardian or Parent if Patient is Under 18 Date

_____ _____ _____
Signature of Witness Relationship to Patient Date