## AUTHORIZATION FOR THE RELEASE OF INFORMATION

**Section A: U.S. GOVERNMENT REGULATIONS REQUIRE THIS FORM BE COMPLETED AND SIGNED BEFORE ANY MEDICAL RECORDS WILL BE RELEASED AND RETAINED ON FILE FOR 7 YEARS.**

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.** I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may no longer be protected by federal privacy regulations.

**Patient Name:** _________________________________ **Date of Birth:** __________________ **ACCOUNT #:** ___________________

**Address:** _______________________________________________________________________ **Phone #:** _____________________

**Persons/organizations providing the information:**

CNE MEDICAL GROUP /
EAST GREENWICH SPINE & SPORT, INC.
1351 SOUTH COUNTY TRAIL, BLDG. 1
EAST GREENWICH, RI 02818
**Provider/Department Name:**

________________________________________

**Persons/organizations authorized to receive information:**

UNIVERSITY ORTHOPEDICS, INC.
2 DUDLEY STREET, SUITE 200, P.O. BOX 1119
PROVIDENCE, RI 02901

**Specific information REQUESTED including dates:**

_______________________________________
_______________________________________
_______________________________________
_______________________________________

**Purpose of disclosure:**

_______________________________________

***OR IF APPLICABLE:***
**circle: ENTIRE MEDICAL RECORD**

**Section B:** Must be completed for all authorizations: **Please check one:** I hereby ___ CONSENT ___ REFUSE to the release of protected health information concerning: Mental Health, Alcohol and/or drug use, sexual abuse, sexually transmitted diseases, AIDS or HIV test results. *(These may or may not be part of your record at University Orthopedics.)*

**Section C:** Must be completed for all authorizations:

**The patient or the patient's representative must read and initial the following statements:**

1. I understand that this authorization will expire one year from the date below. Initials: ________
2. I understand that *I may revoke this authorization* at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions taken prior to the date of revocation. Initials: ________

**Signature of patient or patient's representative (Power of Attorney must be on record)**

_________________________________________________________________________ **Date:** ___________________

**Printed name of patient or patient's representative:** _______________________________________________________

**Relationship to patient (if applicable):** ___________________________________________________________________

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION***