



Address: 1169 Mineral Spring Ave, North Providence, RI 02904

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AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION

I hereby authorize North Providence Pediatrics to,

Obtain my records from: To release my health records to:

Name of physician, hospital, school, childcare and/or other:

Complete Address:

Telephone Number:

I authorize the release and sharing of the protected health and educational records for the patients listed below. I understand that once disclosed, this information may be re-disclosed by the recipient and could lose federal or state privacy protections. This authorization covers faxed documents, phone conversations on mobile or portable devices, and email communications. I acknowledge the reason for this release and understand that the information will be treated as confidential. For matters related to North Providence Pediatrics, I consent to this exchange of information as described.

Patient Name:

Complete Address:

Telephone Number:

Information to be disclosed to / from North Providence Pediatrics - 1169 Mineral Spring Ave, North Providence, RI 02904

<input type="checkbox"/> Complete Records	<input type="checkbox"/> Consult	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> X-Ray	<input type="checkbox"/> Emergency Reports
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Laboratory	<input type="checkbox"/> HIV
<input type="checkbox"/> Outpatient Records	<input type="checkbox"/> Pathology	<input type="checkbox"/> Psychological

Others:

The above information is exchanged / disclosed for the following purposes:

Diagnostic Evaluation / Care Coordination Transfer

I acknowledge that I may withdraw this authorization at any time by sending a written notice to the above-listed hospital, physician practice, childcare provider, school, or other entity — including north providence rhode island pediatrics — unless actions have already been taken in reliance on it or the matter falls within a legally applicable contestability period.

This authorization expires on (upon):

Date or Event:

Signature of Patient or Legal Representative:

Printed Name of Patient or Representative:

Relationship to Patient or Authority to Act for Patient:

Date:

Note: This authorization is deemed invalid unless all fields are completed: