Thundermist HEALTH CENTER

**Our Patient Portal allows for secure access to view, download and transmit your health information online. Please ask if you are interested.**

*AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS & HEALTH CARE INFORMATION*

**1. PATIENT INFORMATION:**

Patient Name _____ Phone Number (_____) _____ D.O.B._____

Address: _____ City:_____ State:_____ Zip: _____

**2. I hereby authorize Thundermist Health Center ATTN: Medical Records Dept**
**25 John A. Cummings Way**
**Woonsocket, RI 02895 Ph# 401-767-4100 Fax# 401-235-6896**

**3. CHOOSE ONE: ☐ To OBTAIN from: (fill out the fields below) OR ☐ to RELEASE records to: (fill out the fields below)**

Name: _____ PH #: (____) _____ FAX#: (____) _____

Address: _____ City:_____ State:_____ Zip: _____

***OR*** ☐ I would like to pick up a ***(select one option)*** ☐ **Paper Copy** ☐ **Electronic Copy (CD)** of my health record on (date): _____. Please allow up to 30 days to process Paper Copy request, 3 days for Electronic Copy (CD) request. If you need your records sooner, or would prefer an alternative electronic format, please ask.

**Fees for Records:** *You may be charged a nominal fee in accordance with state law for the processing of your medical record. This fee will not exceed $25.00.*

**3. Which of the following information do you WANT to be released?**

☐ **Medical Records**
☐ **Dental Records**
☐ **Other** (specify): _____

**4. Specify treatment dates for records to be released: _____ to _____ OR ☐ALL RECORDS**

**5. SENSITIVE INFORMATION: DO NOT release the following information: *(check all that apply)***

☐ HIV/AIDS testing
☐ Sexually Transmitted Diseases
☐ Other (specify): _____
☐ Mental Health or Social Service Counseling notes
☐ Substance Abuse Treatment notes

**6. PURPOSE: Tell us what this records request is for:** *(check one)*

☐ Personal use ☐ Legal matter ☐ Insurance ☐ Treatment by a Specialist ☐ Other: _____
☐ Transferring my care due to: ❍ Moving ❍ Other or Dissatisfied with service provided (please explain): _____
_____

**7. SIGN THE AUTHORIZATION STATEMENT BELOW:**

I understand that I may revoke my authorization in writing any time by notifying Thundermist Health Center. I understand that any previously disclosed information would not be subject to this revocation request. I understand that my records are processed under the Federal Confidentiality Regulations of Alcohol and Drug Abuse Treatment (42 CFR, Part 2) and /or the General Laws of the State of Rhode Island and cannot be disclosed without my written authorization except as otherwise specifically provided by law. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may not then be protected by the Federal Privacy Rule. Therefore, I release Thundermist Health Center, its employees and my physicians from all liability arising from this disclosure of my health information. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, health plan enrollment, or eligibility for benefits. I have read, and understand the above statement and voluntarily consent to the disclosure of information as indicated on this form.

**Unless revoked by the patient in writing, this authorization will expire one (1) year from the designated date signed by the patient below.**

_____ _____ _____
**Signature of Patient/Legal Representative** **Legal Representative's Relationship to Patient** **Date**

_____ _____ _____
**Staff Member Receiving Form (Print Name)** **Phone Ext.** **Date**

******FOR OFFICE USE ONLY******
☐ Obtain request sent on: _____ Initials _____
☐ Records released on: _____ Initials _____