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: Please provide us with your information or your child's information. One person per form.

Patient Name _____ Phone Number _____D.O.B. _____

Address: _____City:_____State:_____Zip: _____

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

2. *Check off OBTAIN, which means we are GETTING your records from another doctor OR check off RELEASE if you would like Thundermist to SEND your Thundermist records to an outside doctor/person. Once one is checked off fill out the information for the facility, we are obtaining from or releasing to.*

CHOOSE ONE:

- ☐ **To OBTAIN-Get records from an outside facility**
- ☐ **To RELEASE-Send records to outside person or self**

☐ Check HERE if you would like us to release your ENTIRE medical record.	**OR**	**Release ONLY these types of records (check all that apply):** ☐ Medical (includes primary care visits and Convenient Care visits) ☐ Dental ☐ Mental Health Treatment ☐ Alcohol/Drug Use and/or Treatment ☐ HIV/AIDS Testing, Diagnosis, and/or Treatment ☐ Sexually Transmitted Infections Testing, Diagnosis, and/or Treatment ☐ Transgender Information and/or Care	**Specify treatment dates for records to be released:** Provide dates of service you would like us to obtain or release. (Last 2 years is what most providers look for, if more information is needed, we can always ask for additional dates of service. ☐ Last Month ☐ Last Six Months ☐ Last Year ☐ Last Two years ☐ ALL ☐ Other (provide dates) _____

3. *Tell us who we should get your records from OR who you want us to send your records to:*

Name: _____ PH #: (_____) _____FAX #: (_____) _____
Address: _____City:_____ State:_____ Zip: _____

*****Only complete this section if you are requesting a copy of your medical records for yourself*****

I would like to: ***(select one option)*** ***Pick up a Paper Copy** ***Electronic Copy emailed to me**

Please allow up to 30 days to process. If you need your records sooner, or would prefer an alternative electronic format, please ask. By providing your email address, you consent for your record to be emailed to you and you understand that unencrypted email may not protect the privacy of your health information.

Email address:_____

***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.*

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

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

_____

5. 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 when the patient is no longer a patient.

_____ _____ _____
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 _____