Medical Release of Information

How can I get a copy of my medical records?

- Please fill out the medical release of information form. You must complete the entire form.
- Important information when filling out the form:
    - **Obtain Records** - You are requesting another provider to send records to Thundermist)
    - **Release Records**- You are requesting Thundermist send records to an outside facility, provider, or hospital. You should also select this option if you would like a copy of Thundermist records for yourself.)
- Enter the information of the person/facility that Thundermist should contact regarding the records. (You must include the correct contact information to allow faster processing)
- Choose the correct option for picking up or emailing the records.
- Please initial which specific sensitive information you would like to release if it exists in the record.
- We recommend only release the last two years of records. If more information is needed, your provider will ask to request additional records.
- ***IF THE FORM IS NOT SIGNED OR DATED, IT IS INVALID AND WILL NOT BE PROCESSED.***
- ***You must complete a form for each facility/provider.***

Do you have questions on how to fill out this form?

Our Medical Records team is here to help you with questions. You can call us at 401-767-4100, option 6. Our hours of operation are 8 a.m. to 4:30 p.m., Monday through Friday.

Did you know the patient portal can help you obtain your medical information faster?

If you do not have Patient Portal Account, you can make a request directly through **Medicalrecords@thundermisthealth.org** or call 401-767-4100, option 6

How do you send the form back to Thundermist?

Please use your preferred method of communication. You can return the form back via email to Medicalrecords@thundermisthealth.org, fax it to 401-235-6896 or mail it to Medical Records Department, 25 John A. Cummings Way, Woonsocket, RI 02895*

(If you are choosing to email the form back by using our email address listed above be sure to provide a clear ***photo or image****. If the form is not readable,* ***we will not be able to process your request****.)*

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
450 Clinton Street, Woonsocket RI 02895 ATTN: Medical Records Dept
Ph# 401-767-4100 Fax# 401-235-6896

2. *Check off if we are Obtaining records which means we are GETTING your records from an outside doctor OR please check off Release if you would like us to SEND your Thundermist records to an outside doctor/person. Once one is checked off please fill out the information for that facility we are releasing/obtaining from.*

CHOOSE ONE: To OBTAIN-Get records from an outside facility To RELEASE-Send records to outside facility
CHOOSE ONE: Medical Records Dental Records Specific Information:___________________________________

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.*
Federal and state laws require special permission to release certain information. Please **initial** next to the information you **WANT** us to send.
We will send the record type in section 2 above PLUS the items you initial below. You **MUST** initial before each item you want us to send:

____Mental Health Treatment ____Substance Use Treatment ____HIV/AIDS ____Sexually Transmitted Infections

4. 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.*
From (date):_________________ To (date): _________________

5. 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):
____

6. SIGN THE AUTHORIZATION STATEMENT BELOW:
Once all fields are completed please sign and date form.

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 ________