AQUIDNECK PEDIATRICS, LLC

1272 West Main Road, Middletown, RI 02842 T: 401-847-2290 F: 401-849-8446

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Please print all information

Name of Patient: ____ DOB: ______________

Patient's Street Address: ____

_______________________________________ Telephone: ___________________________

Reason for request: __ getting second opinion only __ living elsewhere during part of year
__ leaving group due to move ___ leaving group due to dissatisfaction ___ switching PCP
other: _______________________

As the patient or the patient's legal representative, I authorize:

Name of physician: ____
Address of physician: ____

To disclose to:
Name of recipient: ____
Address of recipient: ____

If these records are to be picked up at our offices, I authorize them to be released to:

Name of recipient: ____
Address of recipient: ____
Relationship to patient: ____

MEDICAL RECORDS (*Please check one.*)

□ Information and records or copies of records relating to the history, examination, tests, treatment, and services rendered to me both as an outpatient and/or inpatient in connection with any condition or disease for the purpose of ____.

I specifically ______________________ to the disclosure and release of sensitive medical
(consent or refuse)
information concerning my treatment of mental illness, Human Immunodeficiency Virus, drug addiction, abuse, or dependency, or venereal disease, if any.

□ Only those specific records as I describe:

____

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I may withdraw my consent by giving written consent to the above party, at any time prior to the disclosure or release of the information. In the absence of the withdrawal of permission, this consent will expire one year after it is signed. A photographic copy of this authorization shall be as valid as the original.
Rhode Island law requires medical records to be copied within thirty days from receipt of the request and allows for a reasonable processing fee. I agree to pay this fee.

___________________________________ ___________________________________
Authorized Signature **Date**

___________________________________ ___________________________________
Print Name **Relationship if not patient or custodial parent**
(Must prove guardianship or other legal authorization)

Office use: Record # ______________
Copied by: _____________________ Date: _____________ 02/11