RI SkinDOC

Release of Records

Patient's Name:
_____

Patients Address:
_____

Date of Birth:
_____

Hospital or Provider:
_____

Date(s) Of Treatment:
_____

You are hereby authorized and directed to permit the examination of, and the copying or reproduction in any manner, whether mechanical, photographic, or otherwise, by RISKINDOC, 750 Reservoir Avenue, Cranston, RI 02910 or such persons as they may authorize, all or any portions desired by them of the following:

A. Hospital records, x-ray readings and reports thereof, statements of charges, bills, and any and all records pertaining to hospitalization, history, condition, treatment , diagnosis, prognosis, etiology or expense of the above-referenced patient.

B. Medical records, including patient's, x-rays, x-ray readings and reports, laboratory records and reports, all tests of any type and character, statement of charges, bills, and reports pertaining to medical care, history condition, treatment, diagnosis, prognosis, etiology or expense of the above-referenced patient.

You are authorized to disclose information that is considered sensitive under law, including but not limited to information about me concerning HIV/AIDS infection, sexually transmitted diseases, mental health information, and information concerning treatment for alcohol and/or drug abuse.

You are further authorized and directed to furnish oral and written reports to the above-indicated individual(s), or his/her/their delegates, as requested by him/her/them on any of the foregoing matters, including your diagnosis, interpretation or opinion as to the cause of the said patient's condition or its likely sequelae. This authorization will constitute permission for you to provide said individual(s) or any authorized representative, with periodic updates of the records and bills detailed above subsequent to the date hereof.
By reason of the fact that such information, that you have acquired as a physician, surgeon or other medical care provider/ medical facility/HMO, is confidential, you are also requested to treat such information as confidential and requested not to furnish any of such information in any form to anyone, without written authorization from me or my attorney.
I understand that my records are protected under federal laws and regulations and under the General laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.
I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations.
Therefore I release you, your employees and my physicians from all liability arising from the disclosure of my health information.
I understand that I may revoke this authorization by notifying you in writing. I understand that any previously disclosed information would not be subject to my revocation request.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided
here_____
_____

This form must be fully completed before signing. You are further authorized to treat any copy of this release as an original.

_____ _____
PATIENT, GUARDIAN OR REPRESENTATIVE DATE

Ellen H. Frankel, MD
Michael A. Bharier, MD
Jacqueline Albrikes, MSN, ANP-BC
Stephanie Dadario, MPAS, PA

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Phone: 401-943-0761