Kenneth J. Hopkins
Mayor

Colonel Michael J. Winquist
Chief of Police

"A Nationally Accredited Agency"
DEPARTMENT OF POLICE
5 GARFIELD AVENUE
CRANSTON, RHODE ISLAND 02920
Phone (401) 942-2211
Fax (401) 477-5113

INSTRUCTIONS FOR LICENSE TO CARRY A CONCEALABLE WEAPON RENEWAL

NO APPLICATIONS WILL BE CONSIDERED UNLESS THE FOLLOWING HAVE BEEN ACCOMPLISHED:

1. This official application form must be filled out completely by the applicant then notarized prior to its submission. Please **PRINT OR TYPE** application or ***IT WILL BE RETURNED***.

2. Attention CCW Applicant: Due to a high volume of CCW applications, the Cranston Police Department will no longer accept applications from in-state residents holding out-of-state CCW permits who do not reside in or own a business in the City of Cranston. An exception will be considered for applicants who submit a letter from their hometown Chief indicating they cannot process your application. Provide proof of residency or business ownership (tax bill, utility bill, etc.)

3. Enclose one (1) passport photo Please PRINT applicant's name on the back of each picture. NO laminated photos will be accepted.

4. **Proof of completion of a use of force class (i.e. concealed carry course and/or basic pistol training) along with qualification before a certified weapons instructor; (i.e., N.R.A. Instructor or Police range instructor) must be supplied. A copy of the instructor's NRA/FBI firearms instructor's certification must accompany the qualification.**

5. If the permit is to be used for employment, a **TYPED** letter from the applicant's employer on their letterhead must be included with the application.

6. If the permit is not for employment, a typed letter must be submitted by the applicant stating the reason requesting the license to carry a concealed weapon. All letters must be signed and dated by a Notary Public. We will not accept a photocopy of any signature.

7. Complete the highlighted sections and sign each medical/mental health inquiries and return to the Cranston Police Department with this application.

8. According to RIGL §11-47-12, a permit fee of $40 shall be charged. A check or money order for $40.00 (forty) and made payable to the City of Cranston must be presented when picking up the permit.
   DO NOT SEND ANY CASH, CHECK OR MONEY ORDER WITH YOUR APPLICATION

This application, fingerprint card, and photo become part of the records of the Cranston Police Department.

Kenneth J. Hopkins
Mayor

Colonel Michael J. Winquist
Chief of Police

RENEWAL APPLICATION FOR LICENSE TO CARRY A CONCEALED WEAPON

ACCORDING TO RI GL §11-47-12, A PERMIT FEE OF $40 SHALL BE CHARGED

YOU MUST PROVIDED (1) NEW PASSPORT PHOTO

YOU MUST ALSO PROVIDE PROOF OF RESIDENCY IN FORM OF TAX BILL OR UTILITY BILL

DATE _____ PERMIT NUMBER_____

DATE OF BIRTH _____ PLACE OF BIRTH _____

NAME_____
FIRST MIDDLE LAST

ADDRESS _____
STREET (NO PO BOXES ACCEPTED) CITY STATE ZIP

PHONE _____ _____ _____
HOME BUSINESS CELL

SOCIAL SECURITY NUMBER _____ OCCUPATION _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

HEIGHT _____ WEIGHT _____ EYE COLOR _____ HAIR COLOR _____

**** IF APPLYING AS A BUSINESS ****

BUSINESS NAME _____

BUSINESS ADDRESS _____
Street Name and Number (NO PO Boxes accepted) City or Town State & Zip

JOB DESCRIPTION _____

_____

HAVE YOU EVER ARRESTED IN THE LAST 5 YEARS? _____
(IF YES PLEASE PROVIDE DETAILS ON A SEPARATE TYPED SHEET OF PAPER)

Signed before me, this _____ day of _____, 20____.

_____ _____
Notary Public Signature Applicant Signature

My commission Expires _____

Kenneth J. Hopkins
Mayor

Colonel Michael J. Winquist
Chief of Police

NOTE: THE RI COMBAT COURSE IS FOR LAW ENFORCEMENT PERSONNEL ONLY. ALL OTHERS MUST QUALIFY IN ACCORDANCE TO §11-47-15

WEAPONS QUALIFICATION SCORE: CAL. OF WEAPON _____

ARMY-L _____ SCORE _____ RI COMBAT _____ SCORE _____

_____
SIGNATURE OF N.R.A INSTRUCTOR OR POLICE RANGE OFFICER

_____
PRINTED NAME & TELEPHONE # OF N.R.A. INSTRUCTOR OR POLICE RANGE OFFICER

_____
N.R.A. # OR POLICE DEPARTMENT NAME

****

AFFIDAVIT

I CERTIFY THAT I HAVE READ AND I AM FAMILIAR WITH THE PROVISIONS OF R.I. GEN. LAWS §§ 11-47-1 TO 11-47-63 AND THAT I AM AWARE OF THE PENALITIES FOR VIOLATIONS OF THE PROVISIONS OF §§ 11-47-1 TO 11-47-63. I CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS COMPLETE, TRUE AND CORRECT. I UNDERSTAND THAT A FAILURE TO PROVIDE COMPLETE, TRUE AND CORRECT INFORMATION IN THIS APPLICATION IS CAUSE FOR DENIAL OF THIS APPLICATION AND MAY LEAD TO CRIMINAL PROSECUTION. I FURTHER UNDERSTAND THAT ANY ALTERATION OF ANY CONCEALED WEAPON PERMIT ISSUED BY THE CITY OF CRANSTON IS CAUSE FOR REVOCATION.

_____
APPLICANT'S SIGNATURE

BEFORE A NOTARY PUBLIC
SUBSCRIBED AND SWORN TO BEFORE ME IN _____, RHODE ISLAND

THIS _____ DAY OF _____, 20_____.

_____ _____
Notary Public Signature **Notary Public (Name Printed)**

MY COMMISSION EXPIRES ON _____
Month Year State

FULLER HOSPITAL

— LEADING THE WAY IN BEHAVIORAL HEALTH —

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Current Phone #: _____
Current Address: _____ Last 4 of SS#: _____

To be released to or requested from:

☐ Self (address above)

☐ Cranston Police Department (401) 477-5064 — 5 Garfield Ave

Agency/Organization — Telephone Number — Street Address

Insp. David Boucher — (401)477-5113 — Cranston — RI — 02920

Name / Attention to — Fax Number — City — State — Zip Code

Via (only when released to): ☐ Mail ☐ Fax ☐ Pick-up ☒ Email: DBoucher@cranstonpoliceri.com

☐ Verbal Exchange of Information ONLY

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use

☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☒ Other: Concealed Carry Weapon

Dates of Service Requested: _____

☒ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

☐ **I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records,**

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ Continuity/Transition of Care Packet
☒ Psychiatric Evaluation
☐ History and Physical
☐ Discharge Summary
☐ Progress Notes
☐ Physician Orders
☐ Lab/Diagnostic Reports
☐ HIV Test Results and AIDS Treatment Records
☐ Other: _____

This authorization will expire on ___/___/20___. (If not indicated, authorization will expire <u>one year</u> from signature date)

This form must be completed in full before signing:

_____ _____ _____

Patient's signature (required for ages 18 and older) — Parent/Legal Guardian signature (if applicable) — Relationship to Patient

_____ _____

Witness signature/Credentials — Date Signed

This authorization is intended to allow Fuller Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request. _____ _____

Revocation Signature — Date/Time

10136

Care New England

LABEL

PATIENT

DOB #

AUTHORIZATION TO RELEASE HEALTH INFORMATION

10136 (1-2022)

1. Patient name: _____ ("Patient") Date of Birth: _____ Telephone: _____

   Address: _____ Med. Rec. #: _____
   Street City State Zip

2. The undersigned hereby authorizes the following CNE Provider Butler Hospital
   (Insert Hospital/Facility/Physician name) (the "**Provider**")

   Address: _____
   Street City State Zip

   Telephone: _____ Fax: _____

   ☐ to release/disclose (including verbal) to the individual and/or entity named in Section 3 (**"Recipient"**)
   AND/OR
   ☐ to request/receive (including verbal) from the individual and/or entity named in Section 3 (**"Disclosing Party"**) the protected health information (**"Health Information"**) specified in Section 4

3. Recipient or Disclosing Party: Insp. David Boucher Cranston Police De t. p _____ (Insert Individual/Entity Name)

   Telephone: 401-477-5064 _____ Fax Number (if Health Information is to be faxed): 401-477-5113

   Address: 5 Garfield Ave. Cranston RI 02920 DBoucher@cranstonpoliceri.com _____
   Street City State Zip

4. Please check one or more types of Health Information to be released/requested:

Allergies	_____ Laboratory Results	_____ Operative Report
_____ Immunization Records	_____ X-Ray/Imaging Results	_X_ Psychiatric Exam
_____ Emergency Dept. Records**	History & Physical	_X_ Psychological Tests
_____ Registration Record	_____ Progress Notes	Treatment Plan(s)
_____ Discharge Summary	_____ Consultation Reports	_____ Entire Record

   OTHER (Please specify): _____
   An authorization for Emergency Department Records may include any of the above listed Health Information records.

5. Time frame for which the Health Information authorized in Section 4 above should be released/requested:
   For the period from _____ (insert start date) through _____ (insert end date);
   OR ALL DATES OF TREATMENT _____ (Please initial)

6. The undersigned acknowledges, agrees, and understands that unless specifically limited below, any Health Information released may include mental health treatment information, alcohol and substance abuse treatment information, STDs and/or HIV/AIDS-related information.
   DO NOT RELEASE THE FOLLOWING HEALTH INFORMATION (Please specify): _____

7. This authorization is being requested by the undersigned for the following purpose(s) (initial all that apply)
   _____ Medical Care _____ Legal _____ Insurance _____ Personal
   Other (Please describe): Concealed Carry Permit

8. The undersigned acknowledges and understands each of the following:
   - authorizing the release of the Patient's Health Information is voluntary;
   - refusal to sign this authorization does not affect the Patient's treatment, payment of claims, health plan enrollment or eligibility for benefits;
   - this authorization may be revoked at any time upon written request to the Provider's privacy officer or health information department except to the extent that release of Patient's Health Information has already occurred in reliance on this authorization;
   - unless previously revoked, this authorization will automatically expire TWELVE (12) months from the date of signature below unless a shorter timeframe specified here _____ (enter date authorization will expire);
   - ***any information released to the Recipient may be re-disclosed and may no longer be protected by federal or state privacy and or confidentiality laws.***

THE UNDERSIGNED (1) HAS READ AND UNDERSTANDS THIS AUTHORIZATION; (2) HAS HAD ANY QUESTIONS WITH RESPECT TO THIS AUTHORIZATION EXPLAINED TO HIS/HER SATISFACTION; (3) IS AUTHORIZED TO SIGN THIS AUTHORIZATION INDIVIDUALLY AS THE PATIENT OR AS THE PATIENT'S LEGAL REPRESENTATIVE; AND (4) HEREBY EXPRESSLY AND VOLUNTARILY AUTHORIZES THE RELEASE/ REQUEST OF THE PATIENT'S HEALTH INFORMATION AS SPECIFIED ABOVE.

_____ _____
Signature of Patient or Legal Representative of Patient Date/Time

_____ _____
PRINT name of Patient or Legal Representative of Patient Relationship to Patient or Authority to Act for Patient

TPC Internal Use Only: ☐ Process ☐ Hold

THIS AUTHORIZATION SHALL BE INVALID UNLESS ALL APPLICABLE SECTIONS ARE COMPLETE

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Location of the VA Health Care Facility)*

Providence VA Medical Center (860 Chalkstone Ave., Providence RI 02908)

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS *(including City, State and Zip Code)*

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED Insp.

David Boucher Cranston PD 5 Garfield Ave, Cranston, RI 02920 Fax: 401-477-5113

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify below)*:

Concealed Carry Permit

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ PATIENT MEDICAL RECORDS *(Dates)*: _____

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☐ ADMINISTRATIVE RECORDS: _____

☐ OTHER *(Describe)*: _____

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Mail or Fax Release Form To:
Release of Information
121 Inner Belt Road, Room 240
Somerville, MA 02143-4453
Fax: 617-726-3661
For questions, contact: 617-726-2361
For copies of radiology images or films, contact (617) 855-3385 / Fax (617) 855-3757

Authorization for Release of Protected or Privileged Health Information

Please print all information clearly in order to process your request in a timely manner.

A. Patient information

Patient Name: _____ Date of Birth: _____

Medical Record #: _____

Address: Street: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____

B. Permission to share: I give my permission to share my protected health information.

Records from:

Name of Site Location: _____

Practice Name: _____

_____

Provider Name: _____

Purpose: (check the appropriate box)
- ☐ Medical Care
- ☐ Insurance*
- ☐ Legal*
- ☐ Personal
- ☐ School
- ☒ Other* (please specify) Concealed Carry Permit

**Copying fees may apply*

Send records to (Enter where you would like Mass General Brigham to send your information to):

☐ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below:

Name: Insp David Boucher Cranston Police Dept.

Address: 5 Garfield Ave. Cranston RI 02920

dboucher@cranstonpoliceri.com Fax 401-477-5113

Telephone Number: (401) 477-5064

Send by:
- ☐ Mass General Brigham Patient Gateway (if available)
- ☐ Secure Email
  Email Address: _____
- ☐ Fax (provide fax number): _____
- ☐ Paper Copy via Mail

C. Information to be released (please check all that apply, and MUST specify dates):
- ☐ Date(s) of Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary) _____
- ☐ Date(s) of Clinic Visit Notes _____
- ☐ Date(s) of Discharge Summary _____
- ☐ Date(s) of Lab Reports _____
- ☐ Date(s) of Operative Reports _____
- ☐ Date(s) of Pathology Reports _____
- ☐ Date(s) of Radiation Reports _____
- ☐ Date(s) of Radiology Reports _____
- ☐ Date(s) of Photographs _____
- ☐ Date(s) of Billing Records _____
- ☐ Other (please specify below and include dates)

SCAN TO: PATIENT\HIM ROI AUTHORIZATION

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Mail or Fax Release Form To:
Release of Information
121 Inner Belt Road, Room 240
Somerville, MA 02143-4453
Fax: 617-726-3661
For questions, contact: 617-726-2361
For copies of radiology images or films, contact (617) 855-3385 / Fax (617) 855-3757

Authorization for Release of Protected or Privileged Health Information

D. Please check YES to indicate if you give permission to release the following information if present in your record:

- ☐ Yes — HIV test results (Patient authorization required for each release request.)
  Specify dates _____
- ☐ Yes — Genetic Screening test results
  Specify type of test _____
- ☑ Yes — Substance Use Disorder Treatment Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.) This consent may be revoked upon oral or written request.
- ☑ Yes — Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (I understand that my permission may not be required to release my mental health records for payment purposes)
- ☐ Yes — Confidential Communications with a Licensed Social Worker
- ☐ Yes — Details of Domestic Violence/ Intimate Partner Abuse Counseling
- ☐ Yes — Details of Sexual Assault Counseling

E. I understand and agree that:

- Mass General Brigham cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Mass General Brigham may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
  - if Mass General Brigham has already processed the request (for example, once information is released, it will not be retrieved)
  - if I signed this authorization as a condition of obtaining insurance. Other laws may provide the insurer with a right to contest a claim under the policy or the policy itself
- This authorization will automatically expire 6 months from the date signed unless otherwise specified:_____
- I understand that if Mass General Brigham maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

Patient's Signature: _____ **Date:** _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship of representative to patient:** _____

For Internal Use Only: Information Released/Reviewed By: _____ Date: _____

Picked up by: _____ Pick-up Identification: ☐ License ☐ State ID ☐ Passport ☐ Other Photo ID _____

SCAN TO: PATIENT\HIM ROI AUTHORIZATION

HEALTH INFORMATION SERVICES
AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED INFORMATION

_____ REQUEST COPIES OF MEDICAL RECORD **_____ REVIEW MEDICAL RECORD**

I do hereby authorize the following CharterCARE Health Partners affiliates entities (to include without limitation)

- ☐ Roger Williams Medical Center
- ☐ Roger Williams Medical Associates
- ☐ Elmhurst Extended Care Facility
- ☐ Elmhurst Health Associates
- ☐ St. Joseph Health Services
- ☐ Our Lady of Fatima Ancillary Services
- ☐ Southern New England Rehabilitation Center
- ☒ All

to release my protected health information, including copies of my medical record of care to the following person(s) or persons at the location/facility listed below for the purpose(s) as indicated:

Patient Name: _____ **DOB:** _____
(Last) (First) (M.I.)

Patient Address: _____
_____
_____

Patient Telephone (for contact): ( ) _____ work /home / cell

Email address: _____

Recipient

Insp. David Boucher dboucher@cranstonpoliceri.com
Name
Cranston Police Department 401-477-5064
5 Garfield Ave.
Address
Cranston, RI 02920 Fax 401-477-5113
City, State, Zip Code

Purpose (*check the appropriate box*)

- Medical Care
- X Legal Matter
- Insurance
- Personal
- X Other (please specify) *

* Concealed Weapon Carry Permit

Concerning my treatment for the period of: _____

PROTECTED HEALTH INFORMATION TO BE RELEASED ***(Please check the appropriate box(s) and provide dates):***

- ☐ Discharge Summary (dates) _____
- ☐ Operative Reports (dates) _____
- ☐ Outpatient Test Results (dates) _____
- ☐ X-Rays/Scan Reports (dates) _____
- Pathology Reports (dates) _____
- Emergency Room (dates) _____
- Lab Reports (dates) _____
- Other *(please specify)* _____

☐ Reports ☐ Films ☐ Billing _____

Medical Record Abstract (*e.g. Discharge Summary, Consultations, History & Physical, Operative, Pathology, and Test Reports*)

Authorization for Release of
Specifically Protected Information

I request the release of the specific categories of information that I have *INITIALED* below:

_____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATE(S): _____
_____ Records pertaining to Sexually-Transmitted Diseases
_____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2
(FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

_____ Other(s): Please List _____

Confidential Details of:
__X__ Psychotherapy (from a Psychiatrist, Psychologist, or Psychiatric Clinical Nurse Specialist)
(cannot be authorized in conjunction with non psychotherapy authorization)
__X__ Other professional services of a licensed psychologist
__X__ Social Work Counseling/Therapy
_____ Domestic Violence Victims' Counseling
_____ Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management.
- Authorization may be withdrawn except for the following:
  *To the extent that action has been taken in reliance on this statement
  *If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization.
- If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer protected by this rule.
- I understand that even if I do not withdraw this consent that this statement shall expire in:
  (please check one):____3 months _____6 months____12 months ____Other
  (if no time is indicated authorization will expire in one year)

I have carefully read and understand the above, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ **Date:**_____ Relationship, if not patient_____

Print Name: _____Witness:_____Date:_____

_____
Basis of Authority to act on behalf of the patient

TO BE COMPLETED BY OFFICE STAFF/FACILITY RELEASING INFORMATION:

Date___/___/___ ID Verified: Y / N # Pages (if) Given to Patient_____ Initials: _____

Type of Delivery: Email _____ Mail _____ Other_____

STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILTIES AND HOSPITALS

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. I, _____
(Print first name, last name & date of birth of the Individual for whom information is being requested)

2. I hereby authorize the following information to be released: (check all that apply)

☐ Physician Orders	☐ Treatment Plan	☐ Continuity of Care Forms	☒ Therapy Reports
☐ Progress Notes	☐ Social Service Records	☐ Inter-Agency Referral(s)	☐ Financial Records
☐ Discharge Summary	☐ Laboratory Reports	☐ School/Edu. Records	☐ Billing Requests/Reports
☐ History and Physical	☐ Consultation Reports	☒ Psychology Records	☐ Vocational Records

☒ Other (please be specific) Psychological and/or Substance abuse treatment/counseling

3. **I hereby authorize the following information not to be released*:** (check all that apply)

☐ Substance Abuse/dependency/diagnosis/treatment/referral (42 CFR) ☐ Mental Health/diagnosis/treatment/referral
☒ HIV Test results /AIDS related information/(ARC) diagnosis and/or treatment
☒ Diagnoses and/or treatment relating to other communicable diseases

* This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

4. **My information is to be obtained from:**

ELEANOR SLATER HOSPITAL
(Name of Organization)
P.O. BOX 8269
(Address)
CRANSTON RI,02920
(City/State/Zip)
ALYSSA CARLSON 401-462-3639
(Contact Name and Telephone Number)

5. **My information is to be released to:**

Cranston Police Department 401-477-5064
(Name of Organization)
5 Garfield Ave.
(Address)
Cranston RI 02920 Fax 401-477-5113
(City/State/Zip)
Insp. David Boucher dboucher@cranstonpoliceri.com
(Contact Name and Telephone Number)

6. **This authorization is for information applicable to the time period specified below:**

Method of Communication: ☐ Verbal ☒ Printed Materials

From: _____ To: _____

7. Carry Concealed Weapon Permit
(Indicate the specific purpose or need for this release of information)

8. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal privacy regulations. BHDDH may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization. I understand that I have the right to revoke this authorization in writing at anytime, and that the revocation will be effective except to the extent that the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has already taken action in reliance on my authorization. I understand that if this authorization has not been revoked, it will expire in 90 days from the date of my signature. **My instructions to revoke my authorization should be directed to:**

_____
(Name and address of BHDDH Records person responsible for this request)

9. **Signature of individual:** _____ **Date:** _____

10. Signature of authorized representative _____ Relationship: _____

Print Name: _____ Date: _____

For Office Use Only: Information Released: Y N Date of release: _____
Staff Person Releasing Information: _____