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)
PO Box 8269
(Address)
Cranston, RI 02920
(City/State/Zip)
Alyssa Carl
(Contact Name and Telephone Number)

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

Rep of Cranston Police Department Phone 401-477-5041
(Name of Organization)
5 Garfield Avenue
(Address)
Cranston, RI 02920
(City/State/Zip)

(Contact Name and Telephone Number)

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

From: ALL To: ALL

Method of Communication: ☐ Verbal ☐ Printed Materials

7. Concealed Carry 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 this authorization will remain in effect until I revoke it in writing, or upon my discharge from the hospital. (If not an inpatient, expires within 1 year of date of signature). I further understand that, pursuant to applicable law, certain information may be disclosed without my authorization **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) _____