WellOne Primary Medical and Dental Care

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION

Patient Name_____**Date of Birth**_____

Address_____ **Phone:** _____

Please choose 1 or 2:

☐ **1. I authorize WellOne to release my information to** _____

_____

Address/fax/phone

☐ **2. I authorize**_____

_____

Address/fax/phone

to release my health information to WellOne Primary Medical & Dental Care

Please send this information to:

___ Pascoag office: PO Box 312, Pascoag RI 02859 fax: 401-568-7949, phone: 401-568-7661

___ North Kingstown: 308 Callahan Rd, North Kingstown RI 02852 fax: 401-295-0920, phone 401-295-9706

____Foster: 142 A Danielson Pike, Foster RI 02825 fax 401-647-5380, phone: 401-647-3702

Information which may be disclosed

____A health care summary (discharge summaries, consults, labs, testing, immunizations, office visit notes, surgical reports)

____Entire health record

____Do not release confidential information concerning alcohol and/or drug treatment, and/or other information (specify):_____

I understand that my records are protected under the federal privacy laws and regulations and under the General laws of the state of Rhode Island and cannot be disclosed without my written consent unless otherwise specified by law or regulation. I understand that I may revoke the release of information at any time by notifying WellOne in writing. I understand that any previous disclosed information would not be subject to my revocation requests.

I allow for the release of my information to be written and/or verbal and may be transmitted electronically.

_____

Signature of Patient, Parent or Legally appointed Representative **Date**

_____ _____

Print Parent or Legally appointed Representative **Relationship to Patient**