AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, SIGN, AND RETURN TO: 401 WAMPANOAG TRAIL, EAST PROVIDENCE, RI 02915

I. I, _____, hereby voluntarily authorize the disclosure of
(Name of Client)

information from my health coverage account with HealthSource RI. I understand that this release allows disclosure of health, financial, and other individually identifiable information

My Date of Birth: _____ / _____ / _____ My Social Security Number: _____ - _____ - _____

II. My information is to be disclosed to:	**And is to be disclosed by:**
Name of Person/Organization	*HealthSource RI*
Address	*401 Wampanoag Trail*
City/ST/Zip	*East Providence, RI 02915*

III. The purpose or need for this release of information is:

☐ My own personal and private reasons

☐ Other (*specify*):_____

IV. ☐ All information may be provided

OR

☐ All information except _____ may be provided

V. I understand that I may revoke this authorization in writing at any time to HealthSource RI (HSRI) and Department of Human Services (DHS), and that, if I do, HSRI and DHS may condition my access to services on my decision to revoke. In addition, any information disclosed to HSRI or DHS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. Any information released or received as a result of this consent shall not be further relayed in any way to any person or organization outside HSRI or DHS without additional written consent from me. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below.

_____

(Enter timeframe if different from one year after the date below)

_____ _____

Signature **Date**