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:

_____
Name of Person/Organization

_____
Address

_____
City/ST/Zip

And is to be disclosed by:

HealthSource RI

401 Wampanoag Trail

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). In addition, I acknowledge that 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 law, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], the Privacy Act of 1974 [5 USC 552a] and Section 1411(g) of the Patient Protection and Affordable Care Act. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below.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**