ROGER WILLIAMS UNIVERSITY
AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

By signing below, I authorize_____(the "Authorized Discloser") to disclose my health information ("Information"). I understand that signing this Authorization is **voluntary**.

Student Name:_____ **DOB**:_____

Home Address: _____

Date of last semester attending RWU: _____

Information is to be sent to [*Name and address*]: _____

Information to be disclosed: *Check All Applicable***:**

_____ Entire Medical Record (Fee of $15 for copy of medical record to be paid prior to release)

_____ Laboratory tests
_____ Immunization record
_____ X-ray reports
_____ Outside provider notes
_____ Other (specify) _____

Are there date restrictions on the Information to be disclosed?

____ No ___Yes (specify the timeframe of the records): _____

Purpose(s) of disclosure [*Check one*]:

___ Transfer medical care ____Coordination of care with other medical provider
___ Other (specify): _____

The patient or the patient's legal representative agrees with the following statements:

- I understand that the Information disclosed may include information pertaining to the treatment of drug and alcohol abuse, mental health/illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, hepatitis C or genetics. **If you do <u>not</u> wish for this specific information to be disclosed, please describe the information to be <u>excluded</u>: _____**
- I understand my treatment, payment, enrollment or eligibility for benefits will not be affected if this Authorization is not signed.
- I understand that this Authorization will expire in one (1) year, unless sooner revoked or otherwise particularly specified as follows:__ years/months.
- I understand that I may revoke this Authorization at any time by notifying the Authorized Discloser in writing, but if I do, it will not have any effect on any actions taken before the Authorized Discloser received the revocation.
- I understand that there is potential that the recipient of the Information may re-disclose the Information and the Information may not be protected by federal or state privacy laws.

_____ _____
Signature of patient or patient's legal representative **Date**

Printed name of patient's legal representative:_____

Description of authority to act for the patient:_____