RHODE ISLAND SCHOOL OF DESIGN
Information Release Form
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20 Washington Place
Providence, Rhode Island 02903
(401) 454-6625 P | (401) 454-6628 F
health@risd.edu

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

_____ _____ _____
Last Name First Name Middle Initial

Authorization

I _____, authorize the ***Rhode Island School of Design's Health Services Department*** to use and disclose the protected health information described below to:

_____ _____ _____
Last Name First Name Relationship

_____ _____ _____ _____ _____
Street Apt City/Town State Zip Code Country

_____ _____ _____
Cell Phone Home Phone Office Phone

Effective Period

A. This authorization for release of information covers the period of healthcare from:

□ _____ to _____.
MM/DD/YYYY MM/DD/YYYY

OR

B. □ All past, present, and future periods.

Extent of Authorization

A. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

B. □ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify):
_____
_____

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4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. ***This authorization shall be in force and effect until _____ at which time it expires.***
MM/DD/YYYY

6***. I understand that I have the right to revoke this authorization, in writing, at any time***. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative relationship to patient

_____
Date

_____
Signature of RISD Health Services Representative

_____
Printed name RISD Health Services Representative

_____
Date