5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

# Authorization for Use and Disclosure of Private Health Information

Patient's Name: ___________________________________ Date of Birth: __________________
Previous Name: ___________________________________ Social Security #: _______________

I request and authorize to _____________________________________________ to release healthcare information of the patient named above to:

Dr. Caroline Chang
Rhode Island Dermatology Institute, Inc.
5586 Post Road, Suite 6
East Greenwich, RI 02818

Phone: (401) 398-2500
** **Please FAX to (401) 398-2599** **

**Description of Private Health Information to be Released**

I authorize the above provider to release protected health information to Rhode Island Dermatology, Inc. for the purpose of medical treatment. This may include information pertaining to mental health, alcohol or drug use, and HIV status. This authorization will expire in one year and may be rescinded at any time.

Specific information to be disclosed:

- Problem list or patient summary page
- Pathology reports
- Record of immunizations
- Office notes from the past 2 years
- Diagnostic studies (lab, radiology, etc) from the past 2 years
- Medication list
- Health Maintenance page or records of health maintenance testing

Other: ___________________________________________________________________________

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information described above may be re-disclosed by the recipient and no longer protected by federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person/company specified above except to the extent that the person/company has already taken action on the disclosure provisions contained in this document.

_________________________________________________________ Date: ____________________
(Signature of Patient)