BROWN DERMATOLOGY
BROWN PHYSICIANS, INC.

Mail or Fax Release Form To:
Brown Dermatology Medical Records
110 Elm St. Providence, RI 02903
Phone (401) 443-5124
Fax: (401) 383-7090. Email:
Derm.HIM@brownphysicians.org

Please complete this form in its entirety

AUTHORIZATION to RELEASE MEDICAL RECORD INFORMATION

Patient Name: Please include any alternate names	**Date of Birth**:
Address:	
City/State/Zip:	**Phone:**

1. I hereby authorize my medical record **and all protected healthcare information** including alcohol and/or drug abuse, HIV testing, behavioral health, genetics testing, communicable diseases, sexual and/or domestic abuse and venereal disease to be:

OBTAINED FROM:	**RELEASED TO:**
Name:	**Name:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Phone:	**Phone:**
Fax:	**Fax:**

There may be a fee associated with this request depending on the format used for delivery.
Paper copies: $15.00 flat fee; If recipient accepts electronic copies $6.50 flat fee. Fees for providing copies to attorneys and/or authorized third parties are in accordance with **RI Code of Regulations R5-37-MD/DO: Rules & Regulations Pertaining to Licensure and Discipline of Physicians 11.2 (d).**

2. **Information to be Released: All Records** ☐ **Other:** _____

3. **Treatment dates: From:** _____ **To:** _____ _____

4. **For What Purpose: Transfer out of Brown Dermatology:** ☐ **Continuity of Care:** ☐
Legal: ☐ **Insurance:** ☐ **Other:** _____

Medical information is protected under Federal law and Rhode Island General law 5_37.3 and, except as provided by law, cannot be disclosed without written consent. Information released with authorization will not be given, sold, transferred, or in any way relayed to any other person not specified above.

This AUTHORIZATION will expire one (1) year from the date signed and may be withdrawn at any future time and is subject to revocation with written notice to Brown Dermatology.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Signature of Parent/Legal Guardian (If patient under 18) Date

The information released may be re-disclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Brown Dermatology will not condition treatment on payment of the provision of this authorization.