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PediatricEndocrinology-RI.com

Authorization to Release Information

Patient Name: _____ Date of Birth: _____

I hereby authorize Pediatric Endocrinology of Rhode Island to release all records from either date of inception of Pediatric Endocrinology of Rhode Island (10/2012) or first visit of patient to the present.

Please fax the information to:

Physician or Clinic name:_____

Address:_____

Fax (will not be forwarded unless fax provided):_____

I understand that my authorization will remain effective from the date of my signature for one year and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that my authorization includes the digital transfer of records to a third party records management company on or before October 1, 2020.

I understand that I may revoke the authorization at any time by written, dated communication prior to October 1, 2020.

I also understand that Pediatric Endocrinology of Rhode Island cannot release any records pertaining to care given at Hasbro Children's Hospital Pediatric Endocrinology Service. A release will need to be obtained from Hasbro for those records.

I have read and understand the nature of this release.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Witness Date