Quality Medicine LLC, W. Scott Curtice MD

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AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS & HEALTH CARE INFORMATION

1. Patient Information:

Patient Name_____DOB___/___/_____Phone # _____

Address_____City/State/Zip:_____

2. I hereby authorize Quality Medicine LLC to____Obtain From/____Release to(verbally or written)

Name:_____Fax:_____

Phone:_____Address:_____

3. Which of the following information do you want released?

____Medication list;Problem list; Pap Smear; Mammogram; or Colonoscopy; Most recent PE; Immunization records.
____ Other (specify)_____

4. Sensitive Information-Not to be Released: ***(check all that apply)***

____HIV/AIDS/STD ____Mental Health/Counseling Notes ____Substance Abuse Treatment Notes
____Other (specify)_____

5. Purpose: ***(check one)***

____I am receiving treatment from a specialist
____I am transferring my care to another Healthcare Provider
____Coordination of Care
____Other:_____
____Insurance purposes
____Personal Use
____Legal Matter

6. Authorization Statement:

I understand that I may revoke my authorization in writing any time by notifying Quality Medicine LLC. I understand that any previously disclosed information would not be subject to this revocation request. Unless otherwise revoked, this authorization will expire six(6) months from the date signed below. I understand that my records are processed under the Federal Confidentiality Regulations of Alcohol and dDrug Abuse Treatment(42 CFR, Part2) and/or the General Laws of the State of Rhode Island and cannot be disclosed without my written authorization except as otherwise specifically provided by law. I understand that any disclosure of information carries with it the potential for re-disclosure by the recipient, and that the Federal Privacy Rule may not then protect the information. Therefore, I release Quality Medicine LLC, its employees, and my physicians from all liability arising from this disclosure of my health information. I understand I may refuse to sign this authorization and that my refusal to sign will not affect payment, my ability to obtain treatment, health plan enrollment, or eligibility for benefits. I have read, and understand the above statement and voluntarily consent to this disclosure of information as indicated on this form.

_____ ____/____/_____
Signature of Patient, Parent, or Guardian Date

_____ _____
Please Print Name Relationship to Patient