DocuSign Envelope ID: 950E7C7C-4BC0-4143-882B-6622A5E4AB76

Rhode Island Counseling Associates
1150 Reservoir Avenue, Suite 203
Cranston, RI 02920
P: 401-259-0340 F:401-213-8538

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _______________________Address:___________________

Patient DOB:_____________ Phone: _______________

I authorize Rhode Island Counseling Associates (check all that apply)

☐ release to:
☐ obtain from:
☐ disclose with:

The recipient listed below:
(The recipient may be a doctor, practice, agency, organization, or individual (where the records are coming from or who you are authorizing us to speak with regarding your care).

Name (of other party): ____

Relationship to Patient:(i.e. Dr.'s office, hospital, spouse, relative) ___________

Street Address:_________________

City, State, Zip:___________________

Phone:___________________

Fax: ______________-___

Medical Records	Treatment Summary	Lab Results	Psychiatric Evaluation/Medical History
☐ Yes	☐Yes	☐Yes	☐Yes
☐ No	☐No	☐No	☐No
History/Intake	Diagnosis	Psychological Test Results	
☐ Yes	☐Yes	☐ Yes	
☐ No	☐ No	☐No	
Progress Notes	Other (be specific) ____________________		
☐ Yes	☐Yes		
☐ No	☐No		

For the purpose of ☐evaluation/assessment and/or coordinating treatment efforts. PLEASE FILL OUT ONLY ONE AUTHORIZATION FORM PER RECIPIENT. PLEASE CONTACT THE OFFICE FOR ADDITIONAL RELEASE FORMS.

I understand that this authorization to release information will remain in effect until I revoke it in writing. This is a standing consent and will not result in a release of information unless requested by the recipient listed above. This consent does not permit the recipient to authorize release of my information to a third party.

PATIENT SIGNATURE______________________ DATE:______________PHONE:______________________

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.