



Pursuant to the State of Rhode Island Department of Health Rules and Regulations for the Licensure and Discipline of Physicians, section 11.2, all medical record requests to physicians shall be made in writing or upon receipt of a properly executed Authorization for Release of Health Care Information.

Medical Record Release Authorization

If returning this request form via fax, please send to 401-239-1795.

I, _____, the undersigned, do hereby give permission to Aspire Dermatology to share my protected health information:

Releasing to:

Form with three sections: Another Physician/Group, Myself, and Third Party, each with fields for Name, Address, Phone, and Fax.

Releasing from:

Form with one section: Physician/ Group, with fields for Name, Address, Phone, and Fax. Includes contact information for Aspire Dermatology.

This is a formal request for:

Office notes Pathology Reports Lab reports Specific Record:

For dates ranging between: and

Reason for request:

Coordination of care Change of provider Insurance Purposes Moving Second Opinion Other:

I understand that, according to the Aspire Dermatology notice of privacy policy, a copy of my records will be furnished within 30 days after the receipt of this request.

Patient or Responsible Party Name: Relation: Date of Birth:

Patient or Responsible Party Signature: Date:

For Office Use Only:

Patient name: Physician Initials:

Date of Request: Initials of Employee Processing Request: