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:

- **Another Physician/Group**
  - Name: _____ Phone: _____ Fax: _____
  - Address: _____
- **Myself:**
  - Care of:_____ Relation: _____ For pick up in: __ Riverside __Newport __Johnston
  - Mailing Address: _____
- **Third Party:**
  - Company: _____ Attention to: _____ Fax: _____
  - Address: _____

Releasing from:

- **Physician/ Group**
  - Name: _____ Phone: _____ Fax: _____
  - Address: _____

Information being furnished to Aspire Dermatology can be provided by:

- **Mail:**
  Attn: Medical Records
  51 Long Wharf Mall
  Newport, RI 02840

  Fax: 401-239-1795

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: _____