Date of Request:___________
Initials of Employee
Processing Request: __________

For Office Use Only:

Patient MRN: ________ ____

Amount Due: _____________

Amount Paid: _____________

Pursuant to the State of Rhode Island Department of Health Rules and Regulations for the Licensure and Discipline of Physicians, sec ion 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

PLEASE NOTE: Requests for the patient's records will be billed to the patient according to state regulations. You may have a personal copy delivered to you electronically upon request. There will be a special handling fee of an additional **$20.00** if records must be delivered within 48 hours of the request. Please visit https://health.ri.gov/medicalrecords for the most up to date medical record request fees.

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

This is a formal request for (check all that apply):

- ○ Office notes
- ○ Lab Reports
- ○ Pathology Reports
- ○ Specific Record:______________

*****For dates ranging between**: ____________ and ______________

Reason for request (check all that apply):

- ○ Coordination of care
- ○ Change of provider
- ○ Moving
- ○ Insurance Purposes
- ○ Second Opinion
- ○ Other

RELEASING TO (who do you want to receive your records):

Another Physician/Group

o Name: ________________________________ _ Phone: __________________ Fax: ________________

o Address: ______________________________ _______________________ ____________________

Myself:

o Care of:_____________________ Relation: __________________

o Mailing Address: _________________________ _____________

For pick up in: ○ Riverside ○ Johnston ○ Tiverton ○ Warwick ○ Warren ○ Middletown

Third Party:

o Company: _____________________ Attention to: _________________ Fax: __________________

o Address: ______________________________ _______________________________________

Patient Portal:
o Email Address: __________________________ _____________________

****Patient medical records are available anytime through our patient portal at www.aspiredermatology.com****

RELEASING FROM (who has your records now):

Information being furnished to Aspire Dermatology can be provided by:
Fax: 401-239-1795 **OR** **Mail:** Aspire Dermatology
Attn: Medical Records
102 Valley Road
Middletown, RI 02842

Physician/ Group

o Name: ________________________________ ___ Phone: _________________ Fax:__________________

o Address: ______________________________ _______________________ ______________________

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:** ___________________