Date of Request: _____
Initials of Employee: _____
Processing request: _____

ASPIRE® DERMATOLOGY

For Office Use Only:
Patient MRN: _____
Amount Due: _____
Amount Paid: _____

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.

Patient Name: _____Date of birth: _____

Address: _____ Email Address: _____

I hereby authorize Aspire Dermatology to: ☐ **OBTAIN FROM:** ☐ **RELEASE TO:**

Facility/Provider/Individual

Name: _____ **Phone**: _____ **Fax**: _____

Address: _____

Fax to 401-239-1792 or mailed to Aspire Dermatology, 102 Valley Rd. Middletown, RI 02842 Attn: Medical Records
For records released to an individual - pick up in
☐Riverside ☐ Johnston ☐ Tiverton ☐Warwick ☐ Warren ☐Middletown ☐ Cumberland ☐ Coventry

This is a formal request for (check all that apply)
☐ Office notes ☐ Pathology Reports ☐ Labs Reports ☐ Specific Reports_____

For dates ranging between: _____ and _____

I understand that treatment and coverage is not based upon my signing this authorization. This information is needed for the following reason(s):
☐ Ongoing treatment/aftercare
☐ Transfer of care
☐ At the request of the patient/parent/legal guardian
☐ Other: _____

Release of information requiring specific consent: The following categories of information may be in your medical record and will not be released unless you indicate your authorization by initialing each category you wish to release

_____HIV/AIDS Results/aftercare _____Alcohol/Drug Abuse treatment _____Domestic Violence

- 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
- I understand that this authorization is subject to revocation at any time unless action based on it was already begun. Request for revocation will be done in writing. This authorization expires 90 days from the date of signature.
- I understand that the information may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I further release the person and/or agencies named above from any liability arising from the release of this information to such person and/or agencies, provided the said release of information is done substantially in accordance with the applicable law.

Patient or Responsible Party Name:_____Relation: _____

Patient or Responsible Party Signature:_____Date: _____

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

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 requeststo physicians shall be made in writing or upon receipt of a properly executed Authorization for Release of Health Care Information.