

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



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.

****ALL FIELDS REQUIRED - FAILURE TO COMPLETE MAY RESULT IN DELAY OF REQUEST COMPLETION****

Patient Name: _____ **Date of birth:** _____

Address: _____ **Email Address:** _____

I hereby authorize Aspire Dermatology to (PLEASE SELECT ONE): **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 Narragansett Providence North Kingstown

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
- At the request of the patient/parent/legal guardian
- Transfer of care
- 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.
- I understand these records are available to me at any time via the Aspire Dermatology patient portal to view/download/print as needed

Patient or Responsible Party Name: _____ **Relation:** _____

Patient or Responsible Party Signature: _____ **Date:** _____

****Patient medical records are available anytime to download and print via 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, section 11.2, all medical record requests physicians shall be made in writing or upon receipt of a properly executed Authorization for Release of Health Care Information.