Osteopathic Family Medicine, LLC
Aaron Way, D.O., Jamie Oakley, P.A.C.
55 Cherry Lane Suite 1B Wakefield, RI 02879 Phone: 401-284-4555 Fax: 888-781-7202

1. Patient Information

Name ________________________________ Phone #:______________________________

Date of Birth___________________ Street Address_______________________________

City_______________________ State___________ Zip___________

2. I hereby authorize **Osteopathic Family Medicine, LLC** to:

Obtain from: ☐ **Release my Medical Records to**: ☐ **Discuss my Medical Care with**: ☐

Name: _______________________________ Phone #:____________________ Fax # ______________________

Address____State________ Zip__________

3. Which of the following do you want to be released?

☐ Immunizations, Labs, Most Recent Office Visit, Med List, Chart Summary

☐ Entire Record (You still must check off sensitive information to be released separately)

☐ Other (Specify) ____

4. **Sensitive Information**: The following information **IS** to be released: **(check all that apply) items left unchecked will not be released.**

☐ HIV/AIDS test information ☐ Mental Health notes

☐ Sexually transmitted diseases ☐ Substance Abuse Treatment (alcohol and drug treatment) Notes

☐ Other (Specify)___________________________________

5. **Purpose**: Tell us what this records request is for:

☐ Personal use ☐ Legal matter ☐ Insurance ☐ Referral ☐ Other ______________________

☐ I am transferring care to another provider because _______________________________

6. **Sign the authorization statement below:**

I understand that I may revoke my authorization in writing any time by notifying Osteopathic Family Medicine, LLC. I understand that any previously disclosed information would not be subject to this revocation request. Unless otherwise revoked, this authorization will expire 1 year from the date signed below. I understand that my records are processed under the Health Insurance Portability and Accountability Act and /or the General Laws of the State of Rhode Island and cannot be disclosed without my written authorization except as otherwise specifically provided by law. I understand any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may not then be protected by the Federal Privacy Rule. Therefore, I release Osteopathic Family Medicine, LLC, its employees and my physicians from all liability arising from the disclosure of my health information. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payments, health plan enrollment, or eligibility for benefits. I have read, and understand the above statement and voluntarily consent to the disclosure of information as indicated on this form.

____________________________________ __________________________ ____________
Signature of Patient or Legal Guardian **Relationship to Patient** **Date**