RHODE ISLAND SCHOOL OF DESIGN
Information Release Form

HIPAA Privacy Authorization Form
**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.
Parts 160 and 164)**

Authorization
I _________________________________, authorize the Rhode Island School of Design’s Health Services Department to use and disclose the protected health information described below to:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relationship</th>
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<tbody>
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<thead>
<tr>
<th>Street</th>
<th>Apt</th>
<th>City/Town</th>
<th>State</th>
<th>Zip Code</th>
<th>Country</th>
</tr>
</thead>
<tbody>
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<thead>
<tr>
<th>Cell Phone</th>
<th>Home Phone</th>
<th>Office Phone</th>
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Effective Period
A. This authorization for release of information covers the period of healthcare from:

□ ______________ to ______________.

B. ☐ All past, present, and future periods.

Extent of Authorization
A. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

B. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records
☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment
☐ Other (please specify):
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. **This authorization shall be in force and effect until ________________ at which time it expires.**

   MM/DD/YYYY

6. **I understand that I have the right to revoke this authorization, in writing, at any time.** I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____________________________________________
Signature of patient or personal representative

__________________________________________________________
Printed name of patient or personal representative relationship to patient

_____________________________________________
Date

_____________________________________________
Signature of RISD Health Services Representative

__________________________________________________________
Printed name RISD Health Services Representative

_____________________________________________
Date