AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ Date of Birth_____

Authorize: Drs. Sambandam & Joseph Associates of RI, Inc.
1220 Pontiac Avenue, Suite 101
Cranston, RI 02920
(401) 943-4660

(Circle Once)
Obtain from: NAME:_____

Furnish to: ADDRESS:_____

Furnish to &
Obtain from: _____

Information pertaining to my identity, prognosis, diagnosis or treatment.
Information to be released includes:

_____ Discharge Summary
_____ Progress Notes
_____ History/Physical
_____ Other (Please be Specific):_____
_____
_____

_____ Psychiatric Examination/Treatment Plan
_____ Psychological Tests
_____ Laboratory Data

For date(s) of Service:_____

This information is needed for the following purpose(s):
_____ Patient Care
_____ Other (Please be Specific):_____
_____
_____

I understand that my records are protected under Rhode Island General Law and cannot be disclosed without my written consent except otherwise specifically provided by law. Further, I understand that if records involve alcohol or drug abuse they are also protected under federal regulation 42CFR, Confidentiality of Alcohol and Drug Abuse.

I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclose the above information and/or medical records (including alcohol and drug abuse records of my condition, if relevant) to those persons/agencies named above.

I further release Dr. Sambandam & Joseph Assoc., INC. employees from any liability arising from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law.

This authorization will have a duration of consent no longer than 90 days after the date of this form. I understand that I may revoke my consent at any time except to the extent that action has been taken in reliance on it.

_____ _____
Signature of Patient/Legal Guardian or Parent if Patient is under 18 Date

_____ _____ _____
Signature of Witness Relationship to Patient Date